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*Important Considerations in Serum Treatment of Pneumococcus Pneumonia**

By Frederick T. Lord, M.D., Boston, Mass.

It may be helpful to consider certain matters of importance in reaching an attainable goal in the specific treatment of pneumococcus pneumonia.

Classification of the Pneumonias

The distinction between lobar pneumonia and broncho-pneumonia is at times difficult not only clinically, but also at the postmortem table. Both lesions may be present in the same patient.

It has become customary clinically to refer to the pneumonias which do not conform to the lobar variety as atypical and include the broncho-pneumonias under this term, but the classification into lobar and atypical or broncho-pneumonia is not of practical importance and the pneumonias should so far as possible be classified in accordance with the inciting agent and not with respect to the pathologic anatomy.

It may, in general, be said that pneumococcus pneumonia is usually lobar and that infection with other organisms results in broncho-pneumonia.

The mistake has frequently been made of regarding lobar pneumonia only as amenable to antipneumococcic serum therapy and dismissing broncho-pneumonia from consideration. It should be appreciated, however, that any one type of pneumococcus may cause either lobar or broncho-pneumonia. To be sure, the individual types of pneumococci vary in the frequency with which they are responsible for one or the other form of pneumonia. Thus, Type 1 and Type 2 pneumococci cause lobar pneumonia in a large proportion of the cases, but may also cause broncho-pneumonia. The proportion of those with broncho-pneumonia rises among pneumococcus pneumonias due to other types and, as shown by Finland (Annals Int. Med. 10: 1531, April, 1937) may reach one-third to one-half of the cases.

Early Diagnosis of Pneumonia

In view of the importance of the pneumococcus as a cause of both lobar pneumonia and broncho-pneumonia, the differentiation of the one from the other has lost much of its

* Prepared for publication in The Commonhealth, Massachusetts Department of Public Health, and presented at the meeting of the Penobscot County Medical Association, Bangor, Maine, Nov. 15, 1938.

significance. Lobar pneumonia is, however, of greater relative importance, because of the infrequency with which other than pneumococci are the cause and the high incidence of Types 1 and 2 as inciting agents.

It is fortunately easy to recognize lobar pneumonia at its inception in a large proportion of the cases. In typical instances, there is often the history of a preceding cold. The onset is commonly abrupt with coincident pain in the side, cough and chill or chilliness, rapid elevation of temperature and rusty sputum. This complex of initial symptoms is incomplete in a small proportion of cases. Definite physical signs are not to be expected early in the disease and two to three days may elapse before there is definite evidence of consolidation. In rare instances, examination by other means than x-ray may be negative throughout the illness.

Broncho-pneumonia as a pneumococcus infection, is usually due to Type 3 and still higher types of the pneumococcus. Primary broncho-pneumonia is for the most part a disease of infancy and the first four years of life. After this age, primary broncho-pneumonia is uncommon but may be expected in a proportion not exceeding ten per cent. The essential factor in the production of secondary broncho-pneumonia is the extension downward of an infecting agent and the types of pneumococci or other organisms normally present in the upper parts of the respiratory tract are concerned in the production of the disease. Pneumococci are found in the upper respiratory tract in a large proportion of normal persons. The carrier state may be transient, intermittent or chronic. Among normal individuals without a history of recent exposure to a patient with lobar pneumonia, the pneumococci harbored in the upper respiratory tract are rarely Type 1 or Type 2 and more often Type 3 and still higher types.

In primary pneumococcus broncho-pneumonia, there is, as with lobar pneumonia, usually the history of an acute respiratory infection such as accompanies a cold. The onset is less abrupt than with lobar pneumonia. An initial chill and pain are less often present. The sputum is usually mucopurulent, occasionally rusty. In cases in which pneumococcus broncho-pneumonia is secondary and occurs in the course of other serious illnesses, after childbirth, during the puerperium, or after surgical operation, the onset may be insidious and the pneumonia discovered only in the course of a routine physical examination. The usual occurrence of broncho-pneumonia as a complication of an existing respiratory infection, the insidious onset, irregular course and frequent absence of definite physical signs make the diagnosis of the disease difficult and at times impossible without resort to x-ray examination. In the absence of this means of examination, it often happens that for a time it can only be regarded as probable from the attendant circumstances and the symptoms or signs. It should be appreciated that broncho-pneumonia practically always complicates capillary bronchitis and may be assumed to be present in the disease even in the absence of more definite indications. Broncho-pneumonia should also be suspected, in the course of an acute bronchitis, when the fever persists longer than a few days, or when rales are localized and persist in one place longer than elsewhere, or when, without change in the local signs, there is an abrupt increase in toxic symptoms and elevation of temperature, pulse and respiration. As there are no distinctive features of the different types of pneumococcus infection, resort must be made to the laboratory for the determination of the type of pneumococcus infection in each case of pneumonia.

Types of Pneumococci in Pneumococcus Pneumonia

The incidence of the various types of pneumococci vary at different times and different places. In adults under ordinary circumstances, infection with Type 1 pneumococcus is more common than with other types.

Among 3,066 cases of pneumococcus pneumonia (including both lobar pneumonia and broncho-pneumonia) in adults, investigated by Bullowa & Wilcox (Arch. Int. Med. 59: 394, March, 1937) the average incidence of

the types most frequently encountered in adults was as follows:

Pneumococcus type	Percentage distribution in 3,066 cases
I	23.7
III	9.7
II	8.4
V	7.5
VIII	7.3
VII	6.3
IV	5.8
XIV	2.8
IX	2.2
XVIII	2.1

Typing of Pneumococci

In view of the importance of early specific treatment, determination of the type of infection should be made at the earliest possible moment.

Type determination is more readily made by the examination of sputum than by other means. The specimen of sputum should come from the lung with as little admixture of saliva or nasal secretion as possible. Rusty or blood-streaked material is most likely to show the inciting agent. Small amounts of sputum suffice for typing by the Neufeld method, culture on blood agar and, if necessary, mouse inoculation. It is no longer necessary to obtain the large amounts which were required for typing by the precipitation method. A fresh specimen should be sent at once to the nearest laboratory equipped for typing. It should be collected in a small, clean, dry and preferably sterile, wide-mouthed bottle. Clear glass facilitates the selection by the technician of suitable portions of the specimen. As drying is to be avoided, cardboard sputum boxes are less serviceable and it is best to collect the sputum in the special containers available through local boards of health. No antiseptic should be added to the specimen, as the determination of type may depend on the presence of living organisms. Tuberculosis sputum outfits should not be used as they contain carbolic acid.

Sputum can be obtained from adults in most cases if the physician is sufficiently insistant. When no sputum is available, the type of pneumococcus infection may be determined by the examination of material obtained from the pharynx on a sterile cotton swab. This is replaced in the sterile tube and sent at once to the laboratory where particles of sputum may be removed by twirling the swab rapidly back and forth in a small amount of broth. Application of the Neufeld method to the sediment obtained by centrifuging at high speed may permit identification of the type of pneumococcus at once or incubation of the broth or mouse inoculation with the sediment may give a positive result after the lapse of some hours.

The limited distribution of Types 1 and 2 pneumococci with rare exception to patients with pneumonia or their contacts may be taken to indicate that the finding of one or the other in the sputum of a patient with pneumonia means that the organism is almost certainly the cause of the infection. On the other hand, the finding of one of the higher types commonly present in the normal mouth may mean that the causative organism has been missed and the typing should at once be repeated on another specimen of sputum.

Importance of Blood Cultures

A blood culture should be taken as a routine in all cases and may be the means of making a diagnosis of type when other methods fail. Blood cultures are, however, positive in only a minority of cases. In general, about one-quarter of those with Type 1 and one-third of those with Type 2 pneumococcus pneumonia develop bacteriemia. The blood culture is, thus, more likely to be negative than positive and there is the further disadvantage in the necessity of making the diagnosis of type by this means that it entails loss of time in waiting for the growth of organisms.

In specifically treated cases, a blood culture should be taken immediately preceding the first injection of serum and as occasion may require throughout the illness. The information derived from the blood culture is of great importance in treatment. In Type 1 and Type 2 cases, not treated with serum, the fatality rate is four to five times as high in those with as in those without bacteriemia. The high death rate in bacteriemic cases may

be much reduced by serum treatment, but much larger doses are required. If the blood cultures taken before serum is given are positive, or, if negative, and the progress of the case is unsatisfactory, it is important to continue to take blood cultures at intervals of twenty-four hours or more often.

Failure to determine the presence of bacteriemia in serum-treated cases deprives the physician of one of the most important guides to dosage. In the earlier Massachusetts cases, of 1341 Type 1, 2 or 5 cases (1931-37) blood cultures were taken in only 635, or 47.4 per cent. During the period in which these cases occurred, facilities for taking blood cultures were for the most part available only in the larger hospitals. In February, 1938, Chadwick (Serum Treatment of Pneumonia, N. E. J. of Med. 218: No. 8, 366, Feb. 24, 1938) announced that blood culture outfits could be obtained from laboratories approved by the State Department of Public Health. After the addition of the patient's blood to the culture medium, the outfit should be returned at once to the same laboratory. Postal regulations do not permit the mailing of these blood cultures, and the outfits must therefore be sent by messenger.

It is encouraging to note that in the later Massachusetts experience* (1937-38) of 550 Types 1, 2, 5, 7 and 8 cases, blood cultures were taken in 326, or 59.3 per cent. In this group, though the proportion of those on whom blood cultures were taken has risen about twelve per cent over that in the earlier group (1931-37), lack of information regarding bacteriemia in 40 per cent of the cases and consequent uncertainty regarding the necessary dosage of serum may be regarded as a serious obstacle to adequate specific treatment.

In consequence of the importance of determining the presence or absence of bacteriemia, blood culture medium is part of the necessary equipment for the treatment of pneumonia. With the patient in a hospital and the laboratory nearby, culture medium in cotton-plugged flasks can be used. For use in the home, culture media in rubber-stoppered bottles covered with a gauze cotton hood are available through approved laboratories. Five cubic centimeters of the patient's blood should be added to the 50 c. c. of culture fluid. Caution should be exercised to avoid contamination of the medium in handling. Before blood is obtained, the stopper should be loosened without removing the hood. For the introduction of blood, the bottle is inclined at an angle of about 45 degrees, the hood and stopper together lifted directly upward, blood ejected from the syringe and the hood and stopper replaced. Contamination especially with staphylococci is likely to occur if the stopper itself is handled or if the fringe of the hood is drawn across the mouth of the bottle. In the presence of pneumococci in the sample of blood, growth may be expected after eight to twelve or more hours, and the type determined by the Neufeld method.

* For this and other data dealing with the 1937-38 series, I am indebted to Dr. Frank R. Philbrook.

Results in the Massachusetts Series

The case fatality rate of Type 1 pneumococcus pneumonia untreated with serum is approximately 30 per cent and of Type 2 about 43 per cent. Of 1,451 Type 1 cases in the Massachusetts Pneumonia series, which were treated with serum within the first four days of the illness, 194, or 13.3 per cent died. Of 368 Type 2 cases similarly treated, 80, or 21.7 per cent died. The experience in Massachusetts and elsewhere has demonstrated that specific treatment can be successfully used by physicians in general practice.

The importance of the time element is emphasized by the experience in Massachusetts. Of 1,205 Type 1 cases treated during the first three days, 145 (12 per cent) died, and of 246 treated on the fourth day, 49 (20 per cent) died. If patients with Type 1 pneumococcus pneumonia are treated within the first twenty-four hours, the fatality rate may be reduced to 5 per cent.*

Results and Dosage of Serum

It should be appreciated that variation in individual requirements make it impossible to treat patients by rule of thumb. In estimating the required dosage, reliance must be placed chiefly on the results obtained in large

* Cecil, R.: *J. A. M. A.* 108:689, Feb. 27, 1937.

groups of cases. Decrease in the fatality rates in serum-treated cases below the rates to be expected without such treatment, is the most important index of the degree of success in estimating dosage. The experience in Massachusetts has an important bearing on this problem. Owing to the small number of cases due to infection with other than Types 1 or 2 pneumococcus, the results in these two groups only will be considered.

In 956 Type 1 cases (1931-37) treated with serum of known potency during the first four days of the illness, there were 134 deaths, or 14 per cent. The average total dosage for each case in this group was 87,569 units. In 408 later (1937-38) Type 1 cases treated with serum of known potency during the first four days, 49, or 12 per cent, died. The estimated average total dosage of serum in these cases was 109,900 units.

In appraising these results in Type 1 cases in the Massachusetts series, it is encouraging to note that there has been a reduction from an expected death rate of 30 per cent to 14 per cent and 12 per cent, respectively, as noted above in the two groups, or well over a half.

In 259 Type 2 cases (1931-37) treated with serum of known potency during the first four days, there were 57 deaths, or 22 per cent. The average total dosage for each case in this group was 92,718 units. In 87 later (1937-38) Type 2 cases, 17, or 19.5 per cent, died, and the estimated average total dosage was 110,800 units. As the expected fatality rate in Type 2 cases without serum treatment is 43 per cent, there has been a reduction of well over a half.

Changes of Policy with Respect to the Distribution of Serum

The results presented in Type 1 and 2 cases are based on cases treated within the first four days of the illness. This restriction in the use of serum supplied by the State Department of Public Health was removed in March, 1937 (Chadwick, J. A. M. A. 109: 1926, Dec. 4, 1937). Though the benefits of serum diminish as the days go by after the onset, no time limit can be set beyond which serum is ineffective. Patients should not be deprived of specific treatment even though its use is begun late in the illness.

The amount of serum dispensed by the Department of Public Health for the treatment of a patient with pneumonia is no longer restricted. (Circular, Department of Public Health, Division of Biologic Laboratories, May 3, 1937.)

Dosage of Serum

It is not to be expected that even under the most favorable circumstances every patient with pneumococcus pneumonia can be saved, but the reduction in the fatality rate in the Massachusetts Series falls short of an attainable goal. Among the avoidable causes of failure in specific treatment are a delay in beginning treatment, insufficient dosage, too long intervals between doses, and lack of attention to the requirements of individual patients.

Regarding delay in treatment, it is encouraging to note that while in the first 1,043* Type 1 cases, 17.5 per cent were treated on the first day, 36.8 per cent on the second, 28 per cent on the third and 17.4 per cent on the fourth, in the last 408 cases (1937-38) the corresponding percentages were 23, 40, 21 and 15.6 per cent.

It is to be hoped that in subsequent cases, a very much larger proportion will be treated on the first day of the disease.

It is desirable to give the necessary amount of antibody not only as early as possible, but within as short a time as is consistent with safety. The fatality rate in Type 1 cases of 12 per cent, as in the 1937-38 series, can doubtless be lowered by more careful attention to the individual needs of the patients.

Suggestions regarding dosage are given in detail on the blue sheet which is distributed with the serum. The importance of certain of those recommendations may be emphasized. At present, in Massachusetts, it is recommended, subject to the precautions which must be exercised with respect to treatment with alien serum, that patients with Type 1 pneumococcus pneumonia be

* Including 956 cases treated with serum of known potency and 87 cases with serum of unknown potency.

given an *initial dosage* of *at least* 60,000 units, with Types 2, 5, or 8 *at least* 100,000 units, and with Type 7 *at least* 60,000 to 90,000 units. This is only the *initial course of injections* and does not constitute the *full initial dosage* in all cases.

To secure the initial dosage indicated above, all the serum is not given at one time. The serum is usually administered at two-hour intervals until the dosage decided upon has been given. The customary amount of the first injection is 2 c. c., the second the remainder of the contents of the vial, the third the contents of two vials, and subsequent injections the contents of three or more vials. The amount of serum injected at one time should not exceed 50 c. c. The introduction of the words *at least* before each amount in the paragraph above is to be regarded as a warning to give a larger initial dosage in severe cases and to err rather on the side of too much than too little serum. Then, too, it must be appreciated that these figures refer only to the dosage in the initial course of injections and do not imply that the specific treatment should stop here. In fact, the use of the term initial dosage is of itself an intimation that further dosage may be desirable.

In the scheme outlined, it is recommended, furthermore, that under certain unfavorable circumstances, such as the inauguration of treatment after the third day, with a patient over 40, with pregnancy or during the first week of the puerperium, multilobar involvement and pneumococcus bacteriemia, that the dosage of serum in the initial course of injections be at least doubled.

Having followed the directions thus far, in many cases only a beginning has been made in treatment and subsequent dosage must be estimated in accordance with the needs of each case. Here again it is better to err on the side of safety and give too much rather than too little serum. Additional individual injections of 40,000 to 60,000 units should be given at intervals of every three to four hours, in all severe cases and in any case if the temperature does not fall below 102 degrees F. by rectum within twelve hours of beginning serum treatment, or having fallen, it again rises above this level, if bacteriemia has been demonstrated regardless of the clinical course, or if there is evidence of a spreading lesion. In this group, it is desirable that the serum be given in the larger doses and for a longer period in the presence of two or more of the circumstances mentioned above.

The amount of antibody necessary for successful specific treatment varies within wide limits in different cases. The suggestions with respect to dosage should be taken to indicate that there is wide latitude in the schedule and that the dosage must be adjusted to the needs of the individual patient.

If the patient fails to improve within twenty-four to forty-eight hours after beginning specific therapy, it is desirable to send another specimen of sputum for typing, as a mistake in bacteriologic diagnosis is possible.

Failure to improve after seventy-two hours, suggests the presence of some complication such as empyema.

*Impressions Gained from the Recent National Health Conference in Washington**

W. F. Braasch, M. D., Rochester, Minnesota.

In the first place the gathering in Washington was no conference at all—at least in the generally accepted meaning of that term. As I understand it, the term conference implies an attempt to arrive at a solution of some problem by a group of individuals who might have different opinions but who possess authoritative information concerning the subject in hand. The problem should have free and frank discussion from all sides in order to obtain as much information as possible, and the only objective in mind should be to arrive at conclusions which would be mutually agreeable.

Cleverly Pre-arranged

Instead of a conference, a cleverly pre-arranged program was set up, with the sole objective of publicizing and supporting a program of health reform inspired by federal officials. Invited to the "conference" was a carefully selected group of some 150 individuals, most of whom were known because of their so-called liberal views toward medical care, and who had either written or spoken in behalf of these views. In the group were men and women with a wide assortment of occupations, including many social and welfare workers, magazine editors, newspaper men, and labor union representatives.

To give it an atmosphere of fairness, a small group of physicians representing the American Medical Association was invited. They were quite overwhelmed by the mass of hostile propaganda—and for all practical purposes, they might better have stayed at home. *Conspicuous by their absence were representatives of banking, investment activities, and of industry and manufacturing, who might have been interested in the financing of the vast expenditures involved.* Neither were there any economists or educators who had ever been guilty of entertaining any theories which might be called conservative or reactionary.

Discussions Released in Advance

Much of the time scheduled for the program of the conference was spent in reading the report and recommendations of the governmental health forces. These had been typed previously and had been read and studied by some of the delegates present. They also had been released by previous arrangement for national newspaper publicity from day to day. The discussion which followed was largely pre-arranged and the remarks made by many of those who took part in the discussion were also previously written and dated for publication.

For the most part those who were called upon to discuss the problem were sympathetic with the government program and in most cases urged that even more radical steps be taken.

Emotional Well-wishing

It is difficult to understand the psychology of many of those who were assembled in the conference. One fact stands out above everything else, however, and that is that when it comes to opinions regarding the care of health, many intelligent people base their ideas more on emotion than logic. One wonders how intelligent men and women could make statements which were largely without factual basis and governed purely by emotional well-wishing.

It was surprising as well as discouraging to hear well-meaning representatives of such supposedly well-informed organizations as the Farm Bureau Federation, Parent-Teachers' Association, General Federation of Women's Clubs, and League of Women Voters get up and urge various phases of health socialization without acquainting themselves with all phases of the problems involved. It is to be hoped that these splendid organizations, usually well-informed and unbiased, will in the future get their information on matters of health from all sources, including

* Reprinted from *Minnesota Medicine*, September, 1938, Volume 21, Page 659.

that storehouse of information available at the headquarters of the American Medical Association.

Lay Confusion

One feature of much of the laymen's barrage was a curious confusion of the indigent with the low income groups. Apparently many of the lay speakers failed to realize the fundamental differences in the problems involved in their health supervision. They did not seem to know that the health of the indigent was supposed to be under municipal, state, or federal control. It was rather ironical to hear their outspoken criticism of the failure of government agencies to look after this group properly when governmental control was supposed to be the objective of their arguments.

Doctor Ridiculed

The physician present was placed in a curious position. One almost felt like a social outcast in the group, and a guilty conspirator to block justice and progress. We were placed in the rôle of selfish, narrow-minded individuals, having no vision or ability to sense reform and incapable of managing affairs of health as they should be managed. A jibe or sally at the unfortunate doctor was greeted with a round of laughter or applause. On the other hand, a calm statement showing what the physician or medical societies had already done and were trying to do to improve medical care received scant attention or was greeted with silence.

Sensational Publicity

Another feature of the conference was the sensational publicity of the proceedings by the daily press. Liberal space was given to the Federal Health program as released by the Interdepartmental Committee. Only the sensational features of the discussion were publicized, which were largely radical and in support of the proposed reforms. The remarks made by Dr. West and Dr. Abell, which stated that the medical profession was in sympathy with some features of the federal program, while others were regarded as objectionable, and their statements showing how much already had been accomplished by physicians along these lines, received only abbreviated notice in the press. The contribution of Dr. Cabot, in which he ridiculed the present methods of medical care, and the well merited rebuke by Dr. West, received more headlines than any other feature of the entire conference.

Unfortunately, the introductory remarks made by Dr. Cabot received but little notice but, in all fairness, should be repeated. Before reading his paper he spoke as follows: "I wish to have it distinctly understood that the views I hold in this controversy are my own and in no way represent the attitude of the Mayo Clinic." Instead of publicizing this statement, the newspapers gave the impression that Dr. Cabot spoke as a representative of the Clinic, which was quite contrary to the truth.

A Few Tricks of Their Own

It must be said that the skill with which the proponents of medical socialization have inoculated an increasing circle of the laity with their ideas is most impressive. They have learned all of the tricks practiced by other governmental activities marvelously well and added a few of their own. The way otherwise intelligent laymen mouthed the oft-repeated but incorrectly founded statements concerning lack of medical care is a startling illustration of what skillful propaganda can accomplish.

Purpose

The purpose of the conference was discussed in the introductory remarks of Miss Josephine Roche, the able General Chairman of the Interdepartmental Committee. The federal program for medical reform was discussed in general terms by its progenitor, Dr. Parran, Surgeon General of the United States Public Health Service. His sententious remark to the effect that medical care promises to be the main issue, both political and social, before the American people in the immediate future would seem to give clear warning of the purpose of the government to

invade the promising field of medical care, both therapeutic and preventive, and use it for any political advantage that it may possess. The report of the Technical Committee and the agenda of the conference have been published in detail in recent issues of the *Journal of the American Medical Association.* A synopsis of the recommendations made, with a few random comments, may be of interest.

Program

The Technical Committee's study of health and medical services in the United States indicates that deficiencies in the present health services fall into four broad categories:

1. Preventive health services of the nation as a whole are grossly insufficient.
2. Hospital and other institutional facilities are inadequate in many communities, especially in rural areas, and financial support for hospital care and for professional services in hospitals is both insufficient and precarious, especially for services to people who cannot pay the costs of the care they need.
3. One-third of the population, including persons with or without income, is receiving inadequate or no medical service.
4. An even larger fraction of the population suffers from economic burdens created by illness.

The Committee submitted a program of five recommendations to meet these problems which are as follows:

I. Expansion of public health and maternal and child health services.

A. Expansion of general public health services. It is recommended that Federal participation in the program of preventive health service should be increased and, furthermore, that Federal participation be increased to promote a frontal attack, to (1) eradicate tuberculosis, venereal disease and malaria; (2) control mortality from pneumonia and cancer; and (3) promote mental and industrial hygiene.

B. Expansion of maternal and child health services. This includes provisions for medical and nursing care of mothers and newborn infants; medical care of children; services for crippled children; consultation services of specialists; and more adequate provision for postgraduate training of professional personnel. It includes, also, recommendations for the establishment of numerous health and diagnostic centers for these purposes. The total cost of taking care of the recommendations under A. is estimated at $200,000,000, and under B. $165,000,000, or total of $365,000,000.

II. Expansion of Hospital Facilities. The Committee found hospital facilities inadequate and recommends a ten-year program providing for expansion of the nation's hospital facilities by provision of 360,000 beds, and by construction of 500 health and diagnostic centers. Averaged over a ten-year period the total cost of such a program was estimated at $146,000,000.

III. Medical Care for the Medically Needy. The Committee finds that, based on a National Health Survey, one-third of the population which is in the lower income levels is receiving inadequate general medical service. This applies to (1) persons without income supported by general relief; (2) those supported through old age assistance or work relief, and (3) families with small incomes. Current provisions to assist these people by any local and voluntary organizations and by physicians are not equal to meet the need. The Committee recommends that the Federal government, through grants-in-aid to the states, implement the provision of public medical care to these groups. It is estimated that on the average ten dollars per person annually would be required to meet the minimum needs for essential medical care, hospitalization, and emergency dentistry. This part of the program would probably reach an estimated level of $400,000,000 annually.

No statement was made as to how this money was to be spent, nor to whom it would go.

IV and V include a general program for medical care and insurance against loss of wages during sickness. The Committee states that without great increase in the total national expenditure the burden of sickness cost can be greatly reduced, through appropriate devices to distribute these costs among groups of people and over periods of time. The cost of the insurance and allied program has been estimated at approximately $2,600,000,000 annually.

To finance the program, two sources of funds could be drawn on; (a) general taxation or special tax assessment; (b) specific insurance contributions. The Committee recommends consideration of both methods.

Cost: 30 Billions

The rôle of the Federal Government would be principally that of giving financial and technical aid to the states in the development of procedures largely of their own choice. The maximum annual cost to Federal, State and local governments of all recommendations, other than the insurance features, is estimated at about $850,000,000. Over a period of ten years this would mean $8,500,000,000. **If compulsory health insurance is added to this at an estimated annual expenditure of $2,600,000,000, the ten-year expenditure for this and the other program would amount to more than thirty billion dollars.**

The manner in which the inspired health reformers referred, without batting an eye, to the expenditure of billions was most impressive. If the government is actually called on to meet these demands, it will make the cost of old age and unemployment insurance look like a mere side issue. No doubt the alleged lack of business ability and financial sense in the medico accounts for his inability to disregard, in like manner, the stupendous sums involved.

Some Are of Value

Although it would be impossible to make a detailed review of these proposals in these columns, their comparative value may be summed up as follows: some of the recommendations are well founded and should prove to be of benefit to public health; others are either unnecessary or are not practical; and the rest would do more harm than good. Many features of those recommendations which are largely of a preventive nature will meet with approval by the medical profession, provided that the program can be carried out in close coöperation with and under the control of medical organizations.

Would Alter Medical Practice

Many of the recommendations which would alter if not transform the practice of medicine require careful study and investigation before they can be endorsed by the medical profession. Outstanding among these proposals may be mentioned the establishment of at least 500 health centers throughout the land for the control of tuberculosis, cancer and other lesions, and several thousand centers for the control of child health. These centers will, in order to be complete, necessarily require the services of a host of physicians in various capacities as specialists, technicians, and administrative officers, which, together with allied dental, nursing and technical services, will lead to complete modification of the present methods of medical practice.

It would be quite impossible for any nationwide plan of this kind to escape eventual lay and political control, with leveling and deterioration of service, not to mention professional regimentation and suppression of individual professional initiative.

Based on WPA Figures

Most of the information and recommendations made in the Report of the Technical Committee and most of the statements made by the three introductory speakers on the program regarding the incidence of illness and lack of medical care were based on statistics obtained from the National Health Survey. This survey was made largely by WPA workers over a period of six months under the supervision of the Public Health Service. The resulting statistics are based on a house to house canvass of 740,000 urban and 36,000 rural families. Much of the reported illness and types of disease had no medical confirmation. The fact that the diagnosis and evaluation of reported disease was made without medical training would in itself make the survey of doubtful value.

A review of the survey reveals many other data which might be questionable. For example, statements made by persons on relief or with low incomes as to disease being the cause of their economic status may be biased. The frequency and severity of illness reported by this survey so greatly exceeds that reported by the Committee on Cost of Medical Care and that of the Metropolitan Life Insurance Company, and differs widely in so many other respects with these surveys, that the accuracy of the entire report is open to question.

Open to Question

Many broad conclusions were made from the survey statistics which are open to question, such as the statement that 40 per cent of the persons canvassed were receiving too low an income to maintain them in a healthy condition. This certainly is not true in most sections of the country—and even if it were true the problems involved are more economic than medical. The situation would be changed very little by giving this group more medical care without correcting the economic factors.

The statistics purporting to show the percentage of individuals who receive no medical care are not even probable. Most similar studies have shown that about 50 per cent of the population suffer no illness requiring medical care during any given year. The statistics in regard to relative need and distribution of hospitals in relation to the population have been proved to be quite erroneous by the careful survey carried out under the supervision of the Council on Medical Education and Hospitals. These are random examples but they show how statistics can be made to fit preconceived ideas and used to prove them.

Said Dr. Goldwater

Space will not permit a detailed review of the discussion which followed the reading of the various sections of the Committee Report. I have already indicated the general tenor of the remarks of those who took part. Among those few who discussed the problems from a more conservative angle was Dr. Goldwater of New York City and his remarks deserve special consideration. Unfortunately, space permits only a few quotations from his address, which are as follows:

"The objectives stated by spokesmen for the Interdepartmental Committee are commendable, but the program submitted arrives at its results by methods of calculation that are too simple to be reliable. Neglected illness is not always convertible by means of money grants or administrative measures into illness effectively prevented or cared for. A substantial fraction of increased government expenditure is almost certain to be used for more custodial care.

"Sincere enthusiasts who, thirty years ago, were sure that tuberculosis would be abolished by 1935, are still writing optimistic tuberculosis programs in glamorous terms of hundreds of fresh millions of dollars.

Self-help Preferable

"In health-protection, self-help is preferable to outside aid; government intervention in medicine is desirable as a last, not a first, resort.

"For similar reasons the efforts of county medical societies and of medical coöperatives sponsored by ethical physicians should be encouraged. These efforts are of primary importance in relation to home care, which is of concern to a greater number of individuals than actual or theoretically required institutional care.

"Medical care should be locally, rather than nationally, administered. The effective and economical administration of medical aid for the masses by huge Federal agencies is well nigh impossible.

The vigorous defense by Dr. Fishbein of the methods employed by the American Medical Association and organized medicine, ex-cathedra and also in the abbreviated time allotted him for discussion, should be mentioned. Also among those who contributed from the conservative side Dr. McCormack should be mentioned and Dr. Paullin, Father Schwitalla, Dr. Veeder, and Dr. Meyer.

In the summing up of the evidence for the plaintiffs by E. E. Witte, Professor of Economics, University of Wisconsin, the liberal cohorts were urged to press their cause even more than in the past. He pointed out that in order to obtain real progress action by the separate states would be necessary. He predicted that the honor of being the first state to support a health insurance law would probably go to New York, but that the immediate opportunities in Wisconsin appeared most promising. It would seem that our brethren in Wisconsin will be in for a hard winter and it is up to medical organizations in the surrounding states to give them all the support, both moral and actual, that we can muster.

W. F. Braasch, M. D.

A New Antigen for the Diagnosis of Trichinosis

A new type of antigen—By Associate Zoologist John Bozicevich—of the National Institute of Health (Public Health Reports, December 2, 1938) to be used either as a precipitin or intradermal test is offered in order that more reliable results may be obtained.

Antigen prepared by this method involves the isolation of trichina larvae-drying and extraction with neutral salt solution—without the use of chemical preservatives—has marked specificity and excellent keeping qualities. In establishing the diagnosis implicit reliance should not be placed on a single intradermal or precipitin test but due care exercised in interpreting the clinical symptoms and differential blood picture.

The distribution of this disease correlates closely with the practice of feeding uncooked garbage to hogs. Hogs maintained on this food show an infection incidence of 5% and in the States where this type of feeding is carried on—New York, California, Massachusetts and Pennsylvania—lead all others in reported cases of the disease. Pork and pork products to be safe require cooking until *thoroughly* done. This is a very efficient measure for protection against the disease.

*Advantages and Disadvantages of Graduate Nursing in Small Hospitals**

By Margaret A. Hebert, R. N., Superintendent, Gardiner General Hospital, Gardiner, Maine

About three years ago the Gardiner General Hospital discontinued its training school and began to employ graduate nurses. The most important reason for such a change was due to the fact, that since the requirements to become and remain an accredited School of Nursing had been raised and the standards increased more and more each year, it proved to us that the small school had no longer the right to offer a course to student nurses.

I am not taking the stand, however, that small hospitals have not graduated well trained, efficient nurses because I feel that they have. With the necessary education for a background; a modern equipped hospital; with doctors, who try to be modern in their treatments and technique; supervisors, who have the proper training and interest of the school at heart, ready to instruct and supervise treatments of each individual nurse, which is possible in a small hospital; with affiliations in the services not taken or in the minority in their own hospitals; I cannot help but feel that that nurse is going to find her place in the profession and be able to efficiently fill it. However, the most difficult requirement for us to fulfill seemed to be the affiliation which was necessary for our students to have. At this particular time there seemed to be too many nurses. Not too many good nurses, I don't think, but too many needing help and work; therefore, some of the hospitals which had, up to this time, affiliating courses to offer, had either discontinued them or were not taking on new affiliates. An affiliation in Medical Diseases was next to impossible, consequently, we were obliged to take an affiliation not needed in order to meet that requirement set up by the Board of Registration. This was not fair to the nurse. After carefully studying the many handicaps which our small hospital with a training school must meet, it was my honest desire to do the best I possibly could for the student, it seemed that to give up the school was the only and final way to help the nurse.

Now, when the change was first made, it was an easy matter to get nurses, there seemed to be plenty, but the last two years this does not seem true. I find that the average young nurse does not like to live in a small town especially after having trained or lived in a large city with many advantages offered for recreation. They seem much more independent as to just what they will do and how long they will do it. One ward may have nurses all graduated from different hospitals;—Just imagine, if you can, what has happened to that system or routine that you have had for nine or ten years with a training school.

Again there seems to be a constant changing; they decide they don't like, they want to try private nursing or they have decided to take a special course and you start writing and calling all the registers and hospitals around. She may come to you and explain all this to you and work her notice or she may just say good-night as sweetly as ever to you at 7 P. M. but try and find her at 7 A. M. next morning. This has been to me the most astounding and disappointing thing in nurses of today. At several different times in the past year have I had nurses pack and leave overnight with no idea of responsibility or thought of the hardships it was working on the hospital and no special reason known by anyone for them to leave.

I have also found that a complete graduate nursing staff has increased our payroll greatly. We are carrying about sixteen graduates with an extra helper at times, while in our training school, we had twenty to twenty-two pupil nurses with six graduates. I do feel that the patients are perhaps a little more contented coming in and finding that they are to be cared for by experienced nurses.

My impressions may be very different from other superintendents who have made the change, due to the fact perhaps that I may be a bit old-fashioned in my ideas as to what a nurse should be expected to do. However, I do hope that in our earnest desire to efficiently train our girls today, that we will not spend so much time on the Theory of Nursing that the practical training still needed to care for the patient will be forgotten.

*Read before the 1938 Annual Meeting of the Maine Hospital Association held at Lakewood, August 31, 1938.

Gunshot Wound of the Pregnant Uterus

REPORT OF A CASE

By Robert W. Belknap, M. D., Damariscotta, Maine

While the following case report may not be unique, I do not recall ever having seen or heard of a parallel instance. It is offered as a medical curiosity.

Mrs. B. D., age 24, IV— gravida, six months advanced. Previous pregnancies noteworthy only for size of last baby, which weighed 12¼ pounds at birth.

Patient and her husband had been having marital difficulties. I had seen her three months previously in an hysterical attack. She had threatened suicide. She had been shooting at rats with a .22 caliber rifle. Her husband had hidden the rifle on account of her threats. On the afternoon of June twenty-second she again procured the rifle while alone in the house and, as she stated, tried to point it at her heart. Apparently because of the length of reach necessary to pull the trigger, she only succeeded in placing the muzzle against the lower abdomen. I saw her in about one-half hour and transported her in the back seat of an automobile to the Lincoln County Memorial Hospital. She was immediately placed on the operating table. There was considerable pallor, pulse fair quality, with the wound of entrance about three inches to the left of and below umbilicus. There were powder stains around it but very little external hæmorrhage. She complained of severe abdominal pain.

The wound was swabbed with acriflavine and the field surgically prepared. Under ether anæsthesia the external wound was debrided and the cut extended into a left paramedian incision. The peritoneal cavity was found filled with a large amount of blood and clots. Intestines were well above the bullet track and were apparently uninjured. There was a perforation of the uterus entering to the left of midline near the lower pole and emerging diagonally opposite on the right posterior surface at a somewhat higher level. Blood poured from both uterine wounds. It became a problem what line of procedure to adopt. The uterine fundus was incised and the fœtus delivered. It was dead, with a penetrating wound through the left chest just below the clavicle. Placenta was extracted. Bleeding was profuse from the uterine incision and was welling up from somewhere behind the uterus. It was decided that the uterus was potentially infected and that the possibility of further blood loss from the wounded uterus and placental site justified hysterectomy, therefore a rather hasty Porro amputation was done in a very bloody field. Peritonization of the stump was rather sketchy. With the uterus out of the way, it was apparent that the slug had lodged somewhere in the region of the common iliac vessels. There was a retroperitoneal hematoma in this region, and blood welled up from the track. This was tamponed for a few minutes, and the bleeding lessened. Abdomen was closed without drainage.

The anæsthetist reported her condition rather poor. She was kept on the table in Trendelenberg position while one liter of glucose-saline was administered intravenously, with improvement in quality of pulse.

The next day her pulse was 150, but she did not look to be in very poor condition except for pallor. Hemoglobin was 50%. She was given 900 ml. of whole blood by the Drummond apparatus from her husband, whose blood was found to cross-match.

For a week her temperature ran around 102, pulse 140. There was never evidence of peritonitis, and she appeared quite comfortable. On the second day there was gross blood in the urine. This cleared up in twenty-four hours and recurred in smaller amounts for several days after. It was felt that the right ureter might have been nicked.

Temperature and pulse came down slowly. There was no sign of wound infection, and she went home on the fourteenth day.

Stereoscopic films showed the slug just anterior to the upper part of the right sacroiliac synchondrosis. It would be interesting to place it with reference to the ureter with a pyelogram.

The President's Page

To the Members of the Maine Medical Association:

When this Journal has been released from the press, the Yuletide Season will have passed, but due to the fact that I am writing this page one week before Christmas, I wish to extend to each member of the Maine Medical Association, my best wishes for a Merry Christmas and a Happy New Year.

This is the season of the year when all people should be at peace. Serious matters should not disturb our tranquillity; men's passions should not be in conflict with one another, and as far as humanly possible we should avoid the cares and anxieties which interrupt the calm of our daily lives. In fact there is no other message that expresses my thoughts so clearly as the one taken from the book of St. Luke: "Glory to God in the highest, and on earth peace, good will toward men."

I am not a student of theology but with the present day crisis of greed, selfishness and ambition predominating those characteristics of generosity, unselfishness and humility, one cannot help but wonder if this subject has not been sadly neglected.

We are entering into a new calendar year in the history of our State Society. As it appears now we may be called upon by our government to perform many unpleasant duties. If so, let us face the situation as it may be and never for one moment forget that our Society is founded upon the very highest principles and composed of a selective group of men whose esteemable traits stand second to none.

Willard H. Bunker, M. D.,
President Maine Medical Association.

Editorial

The Human Side of Medicine

The experienced physician knows full well that patients cannot be grouped and treated similar to rabbits, white mice or guinea pigs in a cage; that is, successfully. Patients in the medium and high income groups enjoy and profit from the personal and intimate relationship between themselves and their attending physician. The nearer this ideal can be approached in the low income or indigent groups the better the end results for nothing tends more towards recovery than the knowledge that the attending physician regards one as his personal patient and problem. This fact is one of the important reasons why compulsory insurance in this group far from offers a solution of the economic question now engaging the attention of medicine and allied workers.

The proposals of any department of the central government of the United States to impose such a measure, would, if carried into effect, result in the organization of physicians into gangs dictated to and ruled by a political bureaucracy with complete destruction of professional status and the confidential relationship between physician and patient. One is also hardly off the track when it is realized that once such a segment of the public becomes massed under such control that political preferences might dictate to no small extent the physicians designated to serve under such a system. A doctor working under such conditions would retain a professional status in name only. It would be a job, nothing more and nothing less, and it should be remembered that the "patients" would belong to the insuring power or bureau; not to the doctor. He would continue to hold his job just so long as he remained in the graces of the central authority and agreed to the conditions that it would impose and insist upon. The assurance of a certain income, under such conditions, might appeal to some and as far as was possible most men would give honest and competent service but at any time any or all of the patients could be removed from a given doctor's care or he dismissed entirely.

Before committing the people of this country to a repetition of the blunders and conditions that obtain in some countries it would be well for those who consider such a move, in whole or part, to acquaint themselves with the facts that show that we are living in a period of remarkable achievements in public welfare.

Just off the press in a book entitled, "Medicine in Modern Society" we learn that the author, Dr. David Riesman, "is critical of the association (The A. M. A.) for its stand on the relationship between society and the medical profession." What the stand is that invites such censure we do not know and while we are in accord with the statement that medical service is as vital to the public concern as fire and police protection it might well be said that this idea was suggested a great many years ago by Dr. W. J. Mayo. In fact it was our privilege to hear his remarks on the subject and also his inquiry as to why the profession of medicine should assume its far, far from proportionate share of help to the needy.

Attention

Members and County Secretaries

Again it is called to the attention of members and County Secretaries that the Journal is anxious to receive and publish interesting case reports and clinical suggestions. Those who have the privilege of reading the *New England Journal of Medicine* must be impressed with the value and clinical interest of the case reports published weekly. Many of them show, despite the diagnostic acumen of the attending physicians and the most careful laboratory procedures, "things are not always what they seem." Members reporting their cases direct to the office of the Journal in Portland or any member of the Board can be assured that they will be most welcome.

Graduate Fellowships in Obstetrics and Gynecology

Bingham Associates Fund

The Bingham Associates Fund, by offering Fellowships, is affording practising physicians of Maine the opportunity to pursue a course of graduate study in the field of Obstetrics and Gynecology in Boston. This work will be conducted under the control of the Faculty of Tufts College Medical School. The facilities of the New England Medical Center, the Joseph H. Pratt Diagnostic Hospital, The Boston Dispensary and the Evangeline Booth Maternity Hospital will be utilized.

The Booth Hospital, with about five hundred deliveries a year, is under the control of the Professor of Obstetrics of Tufts College Medical School. All the clinical teaching material at this institution has become available for the benefit of these Fellows. Here, by observation and actual personal delivery of patients, the most modern methods and the most rigid technique of good hospital obstetric practice will be demonstrated and used. Much time will be devoted to prenatal clinic examinations and care, and also to ward rounds for post-partum instruction at the bedside.

This emphasis upon actual experience in the delivery room makes it impossible to maintain any fixed schedule for didactic instruction. As far as possible, however, the course will follow this outline:

Mornings

Eight hours, ward rounds at Booth Hospital. Bedside study of post-partum patients and also of prenatal complications requiring hospitalization.

DR. JOSEPH T. SMITH and ASSISTANTS.

Four hours, Booth Hospital. Pediatrics; care of the new-born.

DR. ELMER W. BARRON.

One hour, Urological Clinic, Boston Dispensary. Special atention to Cystitis and Pyelitis in pregnancy.

DR. BORIS E. GREENBERG.

Four hours, Gynecological Clinic, Boston Dispensary. Case work in office gynecological diagnosis and treatment.

Four hours, Prenatal Clinic, Booth Hospital. History taking, first examinations, follow-up care, treatment of the minor discomforts and complications of pregnancy.

Afternoons

Twelve hours, Obstetrical and Gynecological theory taught through case histories chosen to illustrate major Obstetrical and Gynecological problems. Special attention will be given to the study of abnormal pelves and their relation to complications of labor. Discussion by the Fellows.

One hour, gross and microscopic Pathology. Tufts College Medical School.

Two hours, laboratory, tests and procedures important in Obstetrics and Gynecology. What the doctor should do himself; what he should have done; when and why.

Four hours, manikin drill. The use of forceps, breech extractions, versions.

One hour or more, observing operations, making ward rounds, or attending lectures on Gynecological topics.

DR. L. E. PHANEUF.

Four hours per month, the use of radium in Gynecology.

Four hours per month, the use of X-rays in Obstetrics. The diagnosis of position, multiple pregnancies, etc., by radiation. X-ray pelvimetry.

These Fellowships are for one month each and are available to graduates of regular medical schools. Each one-month Fellowship carries an honorarium of $250.00. Rooms and meals are available for Fellows, at reduced rates, in the Medical Center.

Any doctor wishing to secure such a Fellowship is invited to write to

SAMUEL PROGER, M. D., 25 Bennet Street, Boston, Massachusetts,
FREDERICK R. CARTER, M. D., 22 Arsenal Street, Portland, Maine, or
FREDERICK T. HILL, M. D., The Professional Building, Waterville, Maine.

County News and Notes

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held December 15, 1938, following a banquet at the DeWitt Hotel.

Minutes of the last meeting were read. Dr. Sweatt read a letter from the secretary of the Maine Hospital Association confirming the passage of a resolution concerning hospital insurance plans. Voted that it be put into the records to conform with the minutes of the last meeting.

A report from the special committee concerning present hospital insurance plans was then read. Following discussion upon the subject it was voted to adopt the resolution as submitted, namely, that we should not endorse any particular plan for reasons as set forth by the committee.

The scientific portion of the meeting was devoted towards a general recognition of the past presidents of this society. Dr. Sweatt introduced Dr. W. H. Bunker, president of the Maine Medical Association, as the guest speaker for the evening, who delivered an able and appropriate address for the occasion. It carried considerable of inspiration and thought to the members in the continuance of the spirit of the organization. Dr. George L. Pratt, our President-elect, was also present and extended his greetings for the occasion.

Meeting was adjourned at 10.05.

Respectfully submitted,

A. E. Peters, M. D., *Secretary.*

Cumberland

George A. Tibbetts, of Portland, was elected President of the Cumberland County Medical Society at its annual meeting held at the Eastland Hotel, Portland, Maine, December 9, 1938.

Other officers elected were:

Vice-President, E. H. Drake, Portland.

Secretary-Treasurer, Harold V. Bickmore, Portland.

Councilor for three years, Henry M. Swift, Portland.

Committee on Legislation, Charles B. Sylvester, Portland.

Committee on Public Relations, Donald H. Daniels, Philip H. McCrum and Richard S. Hawkes.

Delegates to the Maine Medical Association 1939 Annual Session: L. A. Brown, W. D. Anderson and J. C. Oram.

Alternates: F. A. Smith, Ralph A. Heifetz and D. H. Daniels.

Maxwell E. Macdonald, M. D., an assistant professor at Tufts, was the speaker of the evening. His subject was *Emotions and Bodily Changes.*

A Clinic was held at the Maine General Hospital, preceding the evening meeting, at which the following program was presented:

Sarcoid ..... Dr. Jack Spencer

Radical Operation for Carcinoma of Scalp.....
Dr. E. S. Lothrop

Renal Tuberculosis ..... Dr. R. H. Huntress

Vitamin Deficiency ..... Dr. T. A. Foster

Visualization of Liver and Spleen with Thorium Dioxide ..... Dr. E. H. Drake

A Case for Diagnosis .....
Drs. Smith, Cutler and Blaisdell

Pyelogram in a 12-Month-Old Child .....
Dr. H. L. Curtis

Harold V. Bickmore, M. D.,
Secretary.

Portland Medical Club

The annual dinner meeting was held at the Columbia Hotel, Tuesday evening, December 6th, at 6.30 P. M. Sixty-one members and three guests were present.

Dr. Léon Babalian, Dr. C. J. Hogan, and Dr. R. T. Phillips were elected members of the Club.

Resolutions on the death of Dr. Willis B. Moulton were adopted by the Club.

Officers for the year 1938-1939 were elected as follows:—

President, Dr. Eugene E. O'Donnell.

First Vice-President, Dr. Theodore Stevens.

Second Vice-President, Dr. Donald H. Daniels.

Secretary-Treasurer, Dr. Alice Whittier.

Board of Censors, Dr. Harold J. Everett, Dr. Oscar R. Johnson, Dr. Richard S. Hawkes.

The annual oration was delivered by Dr. E. W. Gehring. His subject was "The Interrelation Between Medicine and General Economics." This was a very carefully prepared paper and brought out in a clear manner the general economic problems and showed how closely allied to these are the problems of medical economics and how the latter cannot be solved unless those of general economics are also solved.

Alice Whittier, *Secretary.*

Chester F. Hogan, M. D., announces the opening of an office at 131 State Street, Portland, Maine, for the practice of Otolaryngology. Dr. Hogan was formerly a resident Otolaryngologist at St. Luke's Hospital, New York City.

Kennebec

The annual meeting of the Kennebec County Medical Association was held at the Augusta State Hospital, Thursday, December 15, 1938.

Clinical Program: 5 P. M.

Presentation of cases by members of the staff.

Dinner 6.30 P. M.

Followed by business meeting and scientific Session. Minutes of the last meeting were read and approved.

The reports of the secretary and treasurer for 1938 were read and accepted.

The following members were appointed by the Chair to nominate the officers for the ensuing

year: Dr. G. W. Alexander, Gardiner; Dr. G. A. Coombs, Augusta; Dr. J. G. Towne, Waterville.

They reported as follows:

President: Leon D. Herring, M. D., Winthrop.

Vice-President: Blynn O. Goodrich, M. D., Waterville.

Secretary and Treasurer: Frederick R. Carter, M. D., Augusta.

Councilor for three years: Thomas F. Fay, M. D., Augusta.

Delegates to the Maine Medical Association: Samuel H. Kagan, M. D., Augusta; Charles E. Towne, M. D., Waterville.

Alternate: Ivan E. McLaughlin, M. D., Gardiner.

It was moved and seconded that the by-laws be suspended and the Secretary cast one vote for the officers for the ensuing year which was done.

The speaker of the evening was A. Warren Stearns, M. D., Dean, Tufts College Medical School, Boston, Mass., who spoke on Medico-Legal Problems, discussing the responsibility of physicians in criminal cases, tort cases, will cases and brain and nerve injuries. Dr. Stearns is an authority on this subject, a fascinating and brilliant speaker who drew largely from his experience of court and private cases, having been Commissioner of Correction and Prisons for four years, making the subject vital and homely.

In cases involving mental clearness, Dr. Stearns stressed the importance of the physician knowing the general social conditions and situations before deciding doubtful viewpoints. Discussing will cases and contests Dr. Stearns stated "The Doctor has an obligation, not that of a lawyer, detective or mystery fiction writer, but to do his work effectively and honestly.

"The doctor should make an attempt to learn a trustworthy appraisal of the real condition of affairs. The doctor's job is to do medical work, to analyze data properly in order that he may give a real opinion."

Dr. Stearns differentiated medical diagnosis from legal diagnosis. "Skull injuries may result in—(1) cerebral edema, (2) hemorrhage, (3) cerebral laceration. A skull fracture does not necessarily result in brain damage." The doctor stressed the fact that in traumatic neurosis the symptoms may have existed before the accident; that it was a matter of good faith; and that often there was no way of disproving symptoms claimed.

There were 59 members and guests present.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary.

New Members

Androscoggin

James A. Sansoucy, M. D., Lewiston.

Cumberland

Carl C. Corson, M. D., Portland.
Robert T. Phillips, M. D., Portland.
E. Allan McLean, M. D., Portland.

Hancock

James H. Crowe, M. D., Ellsworth.

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*Coming Meetings**

Waldo

Waldo County Medical Society, Raymond L. Torrey, Searsport, Secretary.

The annual meeting of the Waldo County Medical Society will be held at the Windsor Hotel, Belfast, on Thursday evening, January 26, 1939. Dinner at 6.30. *C. B. Popplestone, M. D.*, of Rockland, will present a paper on *Electrocardiography.*

* For more detailed information regarding coming county meetings, write to the County Secretary.

State of Maine Board of Registration of Medicine

Adam P. Leighton, M. D., Secretary.

Physicians licensed to practice medicine and surgery in Maine on November 9, 1938:

Henry Simpson Hebb, M. D., Bridgton, Maine.
Thomas Barr Hoxie, M. D., Belfast, Maine.
Theodore James Hughes, M. D., Portland, Maine.
Paul Adams Jones, M. D., Union, Maine.
Joseph Percy Seltzer, M. D., Fairfield, Maine.

Through Reciprocity.

Harry Brinkman, M. D., Wilton, Maine.
Albert D. Foster, M. D.. Portland, Maine.
Emory Allan McLean, M. D., Portland, Maine.
Willis Bixler Mitchell, M. D., New York City.
Robert Titus Phillips, M. D., Portland, Maine.
Jack Spencer, M. D.. Portland, Maine.

Annual Roster

It is usual at this time to publish the roster of the officers and members of the Association. Owing to the fact that our official list is not correct until the dues of members have been remitted by the County secretaries the official roster will appear in the May number. Members whose names have not been submitted by the County secretaries, as in good standing, must be omitted so an early publication is made so that no embarrassments will follow. At no time in the history of organized medicine has it been more important that members retain their standing in State and County Associations.

Necrology

Ralph D. Simons, M. D., 1877-1938

On Sunday, December 25, 1938, Dr. Simons died at the Gardiner General Hospital, Gardiner, Maine, following a brief illness. He underwent an operation on December 14th and another on December 20th.

He was born at Starks, Maine, January 31, 1877, the son of the late Rev. Elwin Willis and Louise K. (Duley) Simons. He was educated at Madison High School and was graduated from Bowdoin Medical College in 1898. He also studied at the Mayo Foundation.

Dr. Simons began his practice in Kingfield and came to Gardiner in 1902. He was active in both the medical and surgical fields and was a member of the surgical staff at the Gardiner General Hospital, an institution in which he has been active since its inception.

He was a past president of the Kennebec County Medical Association, and a member of the Maine Medical Association and the American Medical Association. He was for several years president of the staff of the Gardiner General Hospital.

Dr. Simons was for many years school physician in Gardiner and annually made the rounds of Gardiner schools to examine the pupils. He was a first lieutenant in the U. S. Army Medical Reserve Corps.

In 1918 he was elected on the Republican ticket to the Maine House of Representatives from Gardiner, and in 1929 he was appointed to the State Board of Registration for Medicine by Governor William T. Gardiner.

His first wife, Alice S. Hunnewell, whom he married in Madison, died in 1912, and in 1914 he married the former Florence T. Hildreth of Gardiner.

Always active in the social life of Gardiner, he was a member of the local Masonic bodies and of Kora Temple, A. A. N. M. S., of Lewiston. He had long been active in the Universalist church of that city.

Dr. Simons is survived by his wife, two sons, Elwin Simons of Whitney Point, N. Y., and Robert L. Simons of Chicago; a half brother, Earl Merrill, sub-master at Machias Normal School; two stepsons, Horace and Charles Hildreth of Portland; and several grandchildren.

Notices

The American College of Physicians Will Meet in New Orleans, La., March 27-31, 1939

The Twenty-third Annual Session of the American College of Physicians will be held in New Orleans, with general headquarters at the Municipal Auditorium, March 27-31, 1939.

Dr. William J. Kerr of San Francisco is President of the College and will have charge of the program of general scientific sessions. Dr. John H. Musser of New Orleans has been appointed General Chairman of the Session, and will be in charge of the program of clinics and demonstrations in the hospitals and medical schools and of the program of round table discussions to be conducted at the headquarters.

Fourth Annual Postgraduate Institute

The Philadelphia County Medical Society desires to announce formally, the completion of its scientific program for the Fourth Annual Postgraduate Institute to be held in the Bellevue-Stratford Hotel, Philadelphia, during the week beginning March 13, 1939. The subjects to be considered are those embraced by the terms "Blood Dyscrasias" and "Metabolic Disorders." These will be further subdivided for convenience in instruction into eighty-six clinical lectures, with open forum discussion for each topic, delivered by as many individual specialists of national distinction.

The Postgraduate Institute aims to fill this need and the participants may be assured that they will unquestionably profit by the program to be presented.

Address all inquiries to The Philadelphia County Medical Society, Twenty-first and Spruce Streets, Philadelphia.

THE COMMITTEE.

Mississippi Valley Medical Society 1939 Essay Award

The Mississippi Valley Medical Society offers a cash prize of $100.00, a gold medal and a certificate of award for the best unpublished essay on a subject of interest and practical value to the general practitioner of medicine. Entrants must be members of the American Medical Association. The winner will be invited to present his contribution before the next annual meeting of the Mississippi Valley Medical Society at Burlington, Iowa, September 27, 28, 29, 1939, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal (Incorporating the Radiologic Review)*. All contributions MUST NOT exceed 5,000 words, be typewritten in English in manuscript form, submitted in five copies, and must be received NOT later than May 1, 1939. Further details may be secured from Harold Swanberg, M. D., Secretary, Mississippi Valley Medical Society, 209-224 W. C. U. Building, Quincy, Ill. The 1938 winning essay, as well as several other essays which received meritorious consideration in the 1938 Essay Contest, appears in the Jan., 1939, issue of the *Mississippi Valley Medical Journal* (Quincy, Ill.).

Book Review

"Interne's Handbook"

By Members of the Faculty of the College of Medicine Syracuse University, under the direction of M. S. Dooley, A. B., M. D., Chairman Publication Committee.

Published by J. B. Lippincott Company, Philadelphia, London, Montreal, 1938. Price, $3.00.

The Second Edition of this pocket-sized Interne's Handbook has been considerably enlarged. A number of entirely new sections have been introduced. The information presented is of such a nature that every practitioner, most certainly every interne, can find ready pointers for emergencies.

The outline for efficient emergency service could perhaps have been still more perfected by stressing the persistence in the efforts at artificial respiration after electric shock, drowning, carbon monoxide poisoning, etc., for several hours without any intermission as recently recommended by several authorities conversant with this subject.

Future editions should also contain sections on the newer industrial poisons as well as on the emergencies related to airplane dispersion of poisonous substances.

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*The Doctor, Family Friend or Public Servant**

Allan Craig, M. D., Medical Director, Eastern Maine General Hospital, Bangor, Maine

I almost called my subject the Great Medical Revolution and perhaps I should have done so except for the fact that the word revolution calls to the minds of most of us violent changes frought with personal disaster to many of those individuals or groups who are involved in it. The change I have in mind is a slower and less violent transformation.

There have been many periods of change in the history of our profession. Some of the changes have been quite radical and many have come about with surprising rapidity although most have been slow in their development and more lasting in their effects.

The great medical change to which I refer this evening began about 1880 and has been steadily but surely moving forward since that time. The entry of medicine as a science into a field heretofore occupied by medicine as an art has come about in the last fifty years. Today medicine is recognized both as an art and a science and it is the welding of these two in one humanitarian profession which in reality constitutes the great medical change. Such changes as this in any profession may constitute a somewhat treacherous adventure unless they are controlled by those with sufficient vision and strength of character to keep them within proper bounds. There is at all times a danger that much of good in both the art and the science be lost in the process of evolution.

The beloved physician — the old family doctor of the past—has left his mark for all time upon the pages of medical history. In magazine stories and upon the screen he is depicted as being always right in his diagnosis whereas the more modern scientific man is depicted as frequently in error. The old doctor was extremely poor in scientific knowledge but strong in human understanding. He was mighty awkward with a microscope or even a blood pressure apparatus, but he was extremely adept in handling patients and their families and their friends. This latter was a real accomplishment. The old doctor understood the interdependence of mind and of body. He was a psychoanalyst before psychoanalysis had become a popular term. In this respect he was an artist.

In the fusing of the art and science of medicine have we not lost a considerable portion of the art? In our busy search for scientific facts which indeed is all important, have we not neglected or overlooked the

* Read before the Eighty-sixth Annual Session of the Maine Medical Association, Bar Harbor, June 28, 1938.

human understanding of the old doctor? Each of us can answer this question only by applying it to himself personally and by an analysis of his own relationships day by day in his practice. As through the years medicine has become more and more of a science —the art of human understanding may have almost unconsciously slipped into the dim shadows of a historic past, and with this evolution public opinion concerning our profession has unquestionably changed. In the days of the old doctor his word was law in the family. His opinion be it right or wrong was respected. Note if you will today how readily people run from one doctor to another; how they will even go bargain-hunting for an operation. We are led to ask ourselves this important question. Do our people —the public—of today have full trust and confidence in us? If they have not, wherein does the fault lie? May it not be that in the search for scientific truth we have not been quite consistent in our approach? Unconsciously we are losing the art of medical practice which should be developed along with the science. The medical student and the interne in our medical schools and hospitals as a rule meets only the patients in the general wards. He seldom learns to consider each patient as an individual. He receives little if any training which will help him to properly understand human relations. The average young medical man of the present day training, unless he is fortunate enough to be personally gifted, goes out into practice with a good working knowledge of scientific medicine and surgery but extremely weak in the intricacies of human understanding. He can learn to meet people and to understand them only through the hard school of personal experience. He is awkward in his approach and often unintentionally offensive.

The public relations of a doctor or a hospital about which we hear so much are but the sum of individual relations. A period of sickness in the home or in the hospital is a red letter period in the patient's life. He will talk about it and write letters about it for years to come. The doctor plays the leading part in that experience and if he is lacking in the art of medical practice, no matter how skilled he may be as a scientist he creates a certain amount of disfavor towards himself and towards the honorable profession which he represents.

Prof. Howard Haggard of Yale in a recent address before the New York Academy of Medicine said: "Medical research is one thing, medical practice is another. In the former field are science, cold facts and cold fact-finders; in the latter are warm-blooded human beings, pursuing what is primarily an art, involving social responsibility and human values. There is today a greater need than ever for socially-minded, public-guiding physicians. The diseases that come to the front in the modern medical readjustment cannot be cured or prevented by impersonal science; they can be controlled only by the close and intelligent coöperation of the individual members of the public with the physician."

For years the medical profession of this country both individually and collectively has opposed the socialization of medical practice. The greatest opponents to the move for state or socialized medicine have not, however, been the doctor or organized medicine, although their opposition has been loud and vigorous. The great restraining force has been the desire of the average man and woman to choose his or her own doctor. That desire of a choice of doctor is born of an individual respect for and confidence in some particular member of our profession.

If then by neglecting the art of medicine we weaken that tie we unquestionably open the way for the advancement of a movement which organized medicine cannot forestall. When our people cease to look upon the doctor as a kindly individual, as a friend in need, as one who practices the art of medicine as well as the science, then public opinion will force upon us a system of state medicine.

Is the doctor of today a family friend or a public servant or a combination of the two? In the opinion of most of us undoubtedly the latter is the case, but in the future will he become only a public servant? Although the medical profession does not wish to see the complete socialization of medical practice so that the practitioner becomes merely a servant of the state, paid by the state, still we cannot but realize that some aid either state or federal must ultimately be provided to

lighten the increasing charity load which our doctors and hospitals are carrying at the present time.

No profession has through the years carried such a great and ever increasing charity load as the medical professionl. Dr. Irvin Abell of Louisville in his recent inaugural address as president of the American Medical Association at San Francisco said: "The country's 130,000 regular physicians are donating probably one million dollars' worth of services daily to indigent and low-income patients, a contribution not equalled or exceeded by any agency other than the Federal Government."

Again and again this problem of caring for the indigent and low-moneyed class of sick and injured presents itself. Again and again an unyielding attitude on the part of organized medicine has prevented any compromise or final solution. Developments within the last year or so, however, indicate an awakening of sound medical thought which is most encouraging.

The services of the physician have a real monetary value. In this state and many others there is a decidedly uneven distribution of charity service in the medical and hospital fields. In other words a few of the larger hospitals and their medical staffs are having a large part of the charity work placed upon them. A large percentage of the town authorities believe that the hospitals in the larger centers are state supported institutions to which they may send all their indigent or reputed indigent sick. As to who pays for the medical treatment and the surgical operations, they never seem to consider that factor worth a thought. There is great need here in Maine for a program of public education to stamp out many of the false ideas concerning medical and hospital care.

During the past five years many false impressions have taken deep root particularly among certain classes of our people. The old spirit of rugged individualism and pride in personal independence seems to be smothered by the doctrines of brain trusters, adventurers in social economics who have no real idea just where they are going or what they are seeking. The effect upon the popular mind is a serious one. The individual who would shirk all responsibility and who desires to live his life as a part of a great national machine is becoming more and more in evidence. That society owes them a living no matter what their personal economic value may be has become the belief and doctrine of numbers of our people. That belief has been fostered, fertilized in its growth, and utilized for political purposes. You and I are aware of this trend no matter what our political leanings may be. It is only fair to consider that in the case of injury or illness to this particular class which I have just mentioned, they will expect the state to extend its responsibilities for their care or in the event of the state not accepting such responsibility, it will fall upon the already overburdened shoulders of the individual medical practitioner. Is he and are the privately endowed hospitals, most of which are already operating at a large deficit, to be left holding the bag?

In conclusion the following facts are in evidence:

1. The physician of today is and must continue to be both a family friend and a public servant.

2. A more compromising and less unyielding attitude toward social problems and state and federal relationships must be assumed by organized medicine.

3. We are in great need in this state of a vigorous campaign of education along the lines of medical and hospital relationships.

This important statement should be driven home. The general hospitals of the state are not state supported institutions and the physicians who attend the ward patients in these hospitals are not paid for their services by either the state or the hospital.

Finally, in their private offices and in our hospital wards the members of the medical profession are making a colossal contribution of professional services for which they receive no remuneration. The burden is becoming too great and a definite compromise arrangement between the state and the private practitioner would seem to offer the only solution to the problem.

Our doctor of the present day is without question partially at least a public servant. Our hope is that in the readjustments of the times he may be able to hold fast to the art of medical practice and remain as ever the family friend.

Gastroscopic Observations on Chronic Gastritis

By Charles W. McClure, M. D., and I. R. Jankelson, M. D.

(From the Gastrointestinal Clinic of the Boston City Hospital, Boston, Mass.)

The present communication reports interpretation of gastroscopic observations made on patients suffering with various types of gastritis. The latter has admittedly been a much abused clinical diagnosis. As an example of this may be cited the custom prevailing during the last century of calling all chronic or intermittent stomach diseases that could not be diagnosed as ulcer or cancer, chronic gastritis. Thus, the diagnosis was made very frequently and often on insufficient evidence. It included a great variety of organic and functional disturbances of the stomach as well as those of other organs within the abdomen. As our diagnostic acumen improved, primarily due to newer methods of examination, this diagnosis became disreputable and largely abandoned. It is true, that at the autopsy table, because of the rapid auto-digestion of the stomach, evidence of chronic inflammation within the gastric mucosa was scanty and often absent. This added to the discredit of the diagnosis of chronic gastritis.

Within this century new evidence was obtained proving beyond a shadow of doubt that chronic inflammatory changes within the stomach are frequent. This new evidence was obtained first through the fixation of the stomach immediately after death as proposed by Faber and Lange (1). By pouring down through a stomach tube formalin solution they succeeded in preventing the auto-digestion of the stomach and were enabled to demonstrate histologically the typical changes of chronic inflammation in the gastric mucosa. With the increasing frequency of gastric resections, histologic examinations confirmed the presence of chronic gastritis in peptic ulcer and gastric carcinoma as formulated by Konjetzny (2) and others. The last but not least method at our disposal is the gastroscope which enables us to study the changes of the gastric mucous membrane in vivo.

As long as the opportunities to see the manifestations of chronic gastritis were limited to surgically resected material in cases of ulcer or cancer of the stomach on the one hand and to the comparatively few cases of primary gastritis seen through the rigid gastroscope on the other hand, our knowledge of this disease was meager and deficient. With the introduction of the Wolf-Schindler semi-flexible gastroscope and the elimination of practically all dangers to this examination, many more direct observations of chronic gastritis, primary as well as secondary in type, became possible. Since chronic gastritis per se seldom leads to death and does not require excision of any part of the stomach, histologic studies of this condition are not frequently possible. Through the semi-flexible gastroscope as yet biopsy specimen cannot be obtained. Therefore, the correlation between the gross appearance of chronic gastritis in vivo and its histologic appearance is still not well established. The difficulties of this correlation are enhanced by the fact that through the gastroscope only the mucous membrane can be observed, whereas the inflammatory changes as seen histologically may be confined mainly to the other layers of the stomach.

It seemed natural to attempt to correlate the evidence of gastritis as obtained by the Roentgen-rays and gastroscopy. Unfortunately, even with the Berg technique the Roentgen-rays can only show the enlarged rugae of chronic hypertrophic gastritis. Not infrequently in such cases gastroscopy fails to confirm the presence of enlarged, thickened or irregular rugae as shown in the following case:

Case I—I. D., O. P. D. No. 502043, female, age 18, was seen first at the gastrointestinal clinic on November 12, 1937, complaining of epigastric pain of one year's duration. This pain was mild and usually occurred one-half hour after meals and radiated into both upper quadrants of the abdomen. There was some belching and nausea. At no time was there any vomiting. Bowels were regular without laxatives. There was no loss

of weight. The physical examination was essentially negative. Gastric analysis after histamine showed a free HCL of 20 and a total acidity of 37. There was no bile, blood or excessive amount of mucus in the gastric contents. A gastrointestinal X-ray examination revealed enlarged rugae of the stomach, interpreted as a hypertrophic gastritis. A gastroscopic examination within a few days of the X-ray examination revealed an entirely normal gastric mucosa without any enlargement or thickening of the rugae.

The classification of such cases presents difficulties. The gastroscopist is apt to ignore the Roentgenologic evidence, the Roentgenologist on the other hand, having a graphic record of his findings, questions the value of the gastroscopist's findings. The clinician, particularly one who has experience in and knows the limitations of both methods, must be the final arbiter in such cases. Aware of the fact that the Roentgen-ray cannot show evidence of atrophic gastritis and that both atrophic and hypertrophic changes are frequently present in the same stomach at the same time, one should be inclined to accept the classification of an experienced gastroscopist in preference to that of a Roentgenologist. The following case is briefly cited to illustrate this point:

Case II—C. P., O. P. D. No. 433895, male, age 28, was first seen at the gastrointestinal clinic in May, 1938. He complained of pain across the abdomen at the level of the umbilicus of approximately 7 weeks' duration. This pain was aggravated by food and reached its highest point of severity 2 hours after a meal. It was not relieved by alkalies. There was no nausea nor vomiting. Bowels were regular. The physical examination was entirely negative. A gastrointestinal X-ray examination revealed no evidence of any pathology or dysfunction. A gastroscopic examination performed within 10 days of the X-ray examination showed marked changes in the gastric mucous membrane. The mucosa of the antrum was definitely hypertrophied, while that of the fundus showed a marked diminution of the rugae and visibility of a fine network of the submucous blood vessels.

Because of these reasons we are subscribing to the classification of gastritis from the point of view of the gastroscopist. Here, again, various classifications were offered by Schindler (3), Moutier (4), Simpson (5) and others. Since Schindler's classification is simple and practical, we are accepting it with some modifications. Schindler's classification is as follows: superficial, hypertrophic, atrophic and post-operative gastritis. It considers only the gross changes of the mucosa as seen through a gastroscope. In our own experience, we find that one must bear in mind the clinical application as well. We are, therefore, presenting the following classification. We feel that gastritis etiologically must be divided into primary and secondary. The secondary gastritis frequently accompanies such intragastric lesions as ulcer, cancer, polyposis as well as extra-gastric conditions like gall bladder disease, duodenal ulcer, cirrhosis of the liver, decompensated heart disease, etc. It is also frequently present in the post-operative stomach. Morphologically the secondary gastritis may simulate a primary one and therefore a differentiation of the two is not possible on its appearance but can be made only after painstaking study of the host from every point of view, including Roentgenologic and laboratory observations. In so far as this is a sine-qua-none, gastroscopy is only an additional though valuable method of observation, which does not exclude any of the older methods at our disposal. With this modification we accept the classification as superficial, atrophic and hypertrophic, adding descriptive adjectives to them as simplex, ulcerative or hemorrhagic. We therefore present the following classification:

Primary Gastritis *Secondary Gastritis*

Superficial
- simplex
- hemorrhagic
- ulcerative

Atrophic
- simplex
- hemorrhagic
- ulcerative

Hypertrophic
- simplex
- hemorrhagic
- ulcerative

As mentioned before, mixed forms of gastritis are common, like superficial and hypertrophic or atrophic and hypertrophic areas in the same stomach. Still further complicating the classification and its application are the edema, spasms and hourglass contractions, which may be superimposed upon a gastritis.

Another problem up to now not sufficiently considered in gastroscopic diagnosis are degenerative changes which undoubtedly occur with advancing years and the frequently seen pigment spots which are probably end-results of previous disease or degenerative changes. One is even inclined to consider some forms of atrophic gastritis as degenerative changes without any inflammatory reaction, as seen for instance in pernicious anemia and avitaminosis.

The correlation of the gastroscopic picture and the clinical manifestations also presents considerable difficulty. There is no doubt that morphologic gastritis may exist in the absence of all symptoms. On the other hand, secondary gastritis may condition to a considerable degree the symptoms of a primary disease, like ulcer, cancer of the stomach or gall bladder disease. The question of chronic gastritis versus gastric neurosis is still not solved and in the individual case may present many or even unsurmountable difficulties. We have repeatedly observed in cases of obviously gastric neurosis atrophic changes in the gastric mucosa. Whether there is a cause and effect or merely coincidence we are not ready to say.

The symptoms of chronic gastritis are well known, but are not diagnostic. The usual symptoms are epigastric distress or fullness more or less related to meals. Belching and gas is common. Heartburn occurring soon to 1 or 2 hours after meals is frequent. Pain is not a common symptom but when present may simulate that of a peptic ulcer. Nausea and anorexia are common. Vomiting occurs in the acute exacerbations of this disease. Hematemesis and melena occasionally occur, and may suggest an ulcer or esophageal varix. Coated tongue, brassy taste are frequent. Bowel disturbances like flatulence, distention, borborygmus, constipation and at times diarrhea are seen in this condition. There may be some epigastric tenderness on abdominal palpation, but frequently the examination is entirely negative. The gastric acidity varies from case to case. Hyperacidity, normal acidity, hypoacidity and anacidity occur. In our own experience we could not establish any relationship between the titre of gastric acidity on the one hand and specific changes in gastric mucous membrane on the other. Hypertrophic gastritis as seen by the gastroscope occurs in the presence of either hyper or hypoacidity, but in our experience not with a true achylia. Atrophic gastritis may show any secretory change including achylia. Superficial gastritis likewise gives no uniform changes in gastric secretion. It is obvious that in the mixed forms of gastritis no one can foretell the secretory response of the stomach to a meal or test meal.

Since the diagnosis of gastritis can be suspected only on the symptoms and since the physical examination gives negative or inconclusive evidence, a clinical diagnosis of this condition cannot be made with any certainty. Gastric analysis and Roentgen-ray evidences are likewise inconclusive. Therefore, the only positive proof of the presence or absence of chronic gastritis can be obtained by gastroscopy. However, the morphologic evidence of gastritis must be interpreted in the light of clinical manifestations and laboratory findings. Whether it is primary or secondary can only be told on the basis of Roentgenologic and clinical observations. The proper classification of gastritis must be based on the gastroscopic evidence. The course of the disease can be evaluated by its clinical course supported by repeated gastroscopic evidence. If one accepts this postulate gastritis is obviously one sphere in which gastroscopy is of paramount importance in diagnosis as well as the evaluation of treatment. The value of gastroscopy, however, is not limited to the diagnosis of gastritis. Many other intragastric lesions can be recognized and differentiated by this procedure. Nevertheless, the field of usefulness of gastroscopy is limited as compared to that of the gastrointestinal Roentgen-ray examination. For that reason it does not replace the latter examination. To the contrary, we have made for ourselves an involiable rule, that every gastroscopy must be preceded by a gastrointestinal Roentgen-

ray examination. Even in the diagnosis of chronic gastritis the evidence obtained by both examinations must be correlated, as they are complementary to one another. Finally, the clinical judgment of the physician is the last resort as in cases of neurosis, psychoneurosis or hysteria with some changes in the gastric mucosa.

Conclusions

Chronic gastritis is a common disease. The signs and symptoms of this condition are not characteristic. The Roentgen-rays likewise are not diagnostic. Gastroscopy not only allows a diagnosis of chronic gastritis, but also permits a proper classification of it. A classification of gastritis based on gastroscopy is offered.

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Non-Profit Hospital Service Plans

As Presented to the Annual Meeting of the Maine Hospital Association, Lakewood, Maine, August 31, 1938

By Eugene H. Young, Executive Director, Associated Hospital Service of Maine, Portland, Maine.

Mr. President and Members of the Maine Hospital Association. It gives me great pleasure to come here and speak to you briefly about the Associated Hospital Service of Maine, and non-profit plans for hospital care.

Mr. Cahalane, Executive Director of the Boston plan, has already covered much of the ground, especially the standards established by the Committee on Hospital Service of the American Hospital Association.

So, I will repeat only where necessary to show our effort to incorporate these standards in the Maine plan.

The Associated Hospital Service of Maine was incorporated and received its Charter from the Attorney-General's Department last May.

The Board is made up of nine Directors, three Hospital Trustees, three Doctors and three Business Men representing the general public, all serving in that capacity without remuneration.

The initial working capital has been provided by individuals interested in making hospital care available to people of moderate and border-line incomes.

All of the hospitals in Portland and the one in Westbrook have signed contracts which will assume the responsibility to provide hospital service in accord with our contract with the subscribers. Our contract also provides for service in non-member hospitals in the event of accident or emergency illness while away from home.

The balance of the hospitals in Maine will be invited to participate in the plan as soon as sufficient outside interest is shown or as soon as time will permit us to develop it.

The annual subscription rates are $10.00 for an individual, $18.00 for husband and wife and $24.00 for the family contract.

These rates are sufficient to remunerate hospitals properly for the service rendered to subscribers and necessary administration expenses.

Adequate reserves will be maintained to cover the unearned portion of advance payments. Any surplus remaining will be built

up as an epidemic reserve. Our present arrangement provides for payment of uniform rates to all member hospitals.

Our plan will in no way interfere with existing relationships between Doctors and Hospitals or between Doctors and Patients.

And I would like to say right here,—no matter how well perfected any plan of this kind may be, to a large degree its success will be measured by the amount of coöperation it receives from the medical profession and hospital administrators.

Promotion and administration of the plan will be dignified and consistent with the professional ideals of the hospitals.

Here is the first question which one might easily ask,—Is there a need for non-profit plans? "Let's take a look at the record" and here is what we would find.

Even in that famous and supposedly prosperous year—1929—that the first three-cents-a-day plan was started, over two million of the seven million citizens who required hospital care received it free of charge from State hospitals, and another group of over a million were cared for by privately endowed hospitals. Those people were not down and out. They were not unemployed. They were able to buy food, clothing, shelter and other ordinary things out of their salaries and wages. These things cost about the same from month to month and people could budget for them. But you cannot budget for appendicitis or a broken leg, and even in 1929 millions of people simply could not afford to pay relatively large sums for hospital care and so they were hospitalized at the expense of the State or in hospitals kept going by private donations. This does not mean that these people were parasites. By and large they were not looking for something for nothing. Neither were they so poor that they could not pay something. The point is, that they could not lay out a lot of money at one time and there was no provision or method by which they could buy hospital care on an easy payment plan.

Today about fifty or sixty communities either have full-fledged non-profit plans in operation or are developing them, and it has been estimated that nearly two million persons are enrolled.

No two plans are alike in detail nor do they use the same corporate names but they are alike in principle, namely, groups of individuals make equal and regular payments to a common fund (the association) which is used for the purchase of hospital care for themselves or their dependents.

The systematic payments made by subscribers in non-profit plans tend to reduce the risk and load which has been carried by the hospitals in the past.

The Association also enters into contracts with hospitals which provide certain service to these subscribers that rely upon the hospital service plan for payments.

The hospitals of this State are as should be, coöperative rather than competitive institutions. For this reason the American Hospital Association does not recommend the establishment of more than one non-profit plan in each community. Too much emphasis cannot be placed upon the opportunity for all hospitals of standing to participate in the same non-profit plan.

The subscriber to the Maine plan will receive for his three-cents-a-day or about ten dollars a year, three weeks of hospitalization in a semi-private room. This period may be used up, on one or more visits. Of course the sick subscriber gets more than a bed because they need other things. The benefits included under our plan cover the treatment and care of all illness and injuries regularly accepted for treatment by the member hospital selected by the subscriber, including X-ray, laboratory examinations, anesthesia, free use of the operating rooms and hospital maternity care. A large number of subscribers or their dependents are expectant mothers and under the Maine plan they are given free use of the delivery room, board, laboratory examinations, medicines, dressings and nursery care of the newborn child. The services of the Doctor are of course not included because the plan provides only for hospital care and not for medical or surgical services, and no provision is made for special private nursing.

There are family, as well as individual memberships available to subscribers. A family arrangement includes husband, wife and all unmarried children under age nineteen. In the Maine plan a family membership is only $24.00 a year or $2.00 a month no matter how many children are included.

One great advantage of all the plans, however much they differ in detail throughout the country, is that they are free of red tape. If a subscriber's doctor sends him to a member hospital, the patient simply presents his identification card and he is then treated during his entire stay as though he had paid all his hospital bills in advance.

Can you hospital superintendents and trustees concerned with balanced budgets imagine ward patients being admitted to semi-private rooms with all the charges paid in advance?

That is what it really amounts to when a subscriber enrolls in a non-profit plan and pays his premium in advance or agrees to make installment payments through his place of employment, for an annual hospital service contract. The association merely acts as the clearing-house and custodian of the funds until hospital care is needed.

The three-cents-a-day plan represents a common sense solution to a problem that confronts millions of American families every year, and I am glad that it is being solved by the people themselves, by enrollment in these non-profit plans. This is just another social invention which Americans have made voluntarily.

The plan exemplifies the American ideal of individual initiative and social responsibility without political interference.

Case History

Mrs. L. B., Maine General Hospital, No. 2215. Admitted November 17, 1938, complaining of difficulty in respiration of about two months' duration.

Past History: Essentially negative save for usual childhood exanthema. No operations. Never been gravid. Menses normal. Menopause at 42. G. U. negative. No nocturia, dysuria or hematuria. No dyspnea or orthopnea other than as stated in P. I. Patient has been a known diabetic for about two years. Has been getting along on a diet of her own making, restricting the use of sugar only. About two years ago she started to lose weight, had a great deal of pruritis about the anus and vulva without evidence of rash or discoloration. This she states ceased on a diet but she has continued to lose weight. Original weight 200 pounds. Weight on admission 140 pounds. Has had polydipsia and polyuria. About two months ago had a severe bronchitis with a productive cough which lasted some time. A residual, slightly productive cough still persists with bloody expectoration. No night sweats but marked feeling of weakness. She has been rather drowsy the last few days with increasing difficulty in breathing. Skin dry.

Physical Examination: Well developed obese adult female lying quietly in bed, breathing with some difficulty. Skin and sclera clear. Normal female distribution of hair. Head, no masses or tenderness. Hair, fine, gray. Eyes, pupils round, regular and equal. React to light and accommodation. No petechiae. Scleræ clear. Ears, no mastoid tenderness, no discharge.

Nose:—No discharge.

Mouth:—Teeth fair, pharynx slightly injected. Tongue protrudes in mid line without tremor, slightly coated. Buccal m.m. clear. No petechiae.

Neck:—Not stiff, Trachea in mid line. Thyroid not palpable. Cervical lymphadenopathy.

Chest:—Slight splinting of left chest on respiration. Area of increased whispered voice and breath sounds in left chest, lower and upper lobes posteriorly. Expirations slightly prolonged throughout.

Heart:—No increase in size, sounds good quality, regular rate and rhythm, 110, no murmurs. B. P. 90 systolic, 64 diastolic.

Abdomen:—Soft, symmetrical, no tenderness, no masses or viscera palpable. No C. V. A. tenderness.

Extremities:—Cold and dry, marked varicosities of both legs. No evidence of infection in extremities. Reflexes equal and physiological.

The temperature was 98° F., pulse 110, and respirations 30.

Urine, on admittance:

sugar, yellow
Acet. 3 plus
Diac. 3 plus

Blood sugar 330.

Blood Report:

Hemoglobin	88%
R. B. C.	5,640,000
W. B. C.	9,500
Neut.	68%
Eosin.	2%
Baso.	2%
Lymph.	23%
Mono.	.7%

X-Ray of Chest:

The entire left chest involved with an almost confluent consolidation which extends up to the anterior first lobe. Shows a patchy increase in density. The *right* lower lobe is clear. Trachea in mid line.

Patient was put on a diabetic diet and given Insulin. The blood dropped to normal limits under this regime. Temperature swinging from 98° to, on one occasion, as high as 101°. Sedimentation rate 0. Repeated sputa examinations revealed the acid fast bacillus. Patient was taught to give Insulin to herself and because the diabetes was under control it was deemed advisable for her to return home and be admitted to a Sanatorium for treatment of pulmonary condition.

Just as the patient was leaving the hospital she experienced a severe pain in her chest, became cyanotic with rapid increase in respiration and expired within fifteen minutes.

On the day of discharge patient had complained of pain in left leg to her family but not to the staff.

Clinical Diagnosis

Pulmonary Embolus
Diabetes mellitus
Pulmonary tuberculosis
Varicose Veins

Pathological Report

Description: Body is that of a well developed and nourished female, 162 cm. in length. Hair gray. Pupils equal, 5mm. Marked varicosities in both lower extremities. On making incision through abdominal wall, a small vessel is found in subcutaneous fat which contains a thrombus. Veins of both lower legs are dilated, tortuous, and solid.

Lymph nodes: No G. G. E.

Mediastinum: On opening pulmonary artery, ante-mortem thrombi are found in right and left arteries.

Pleural Cavities: Fairly easily broken up adhesions over apex of left lung. Many firmer adhesions between right lung anteriorly and chest. No fluid.

Rt. Lung: 250 gms. Evidently contracted; rather beefy, and air-containing. On palpation, it is full of nodules. On cut surface nodules appear as grayish-red raised areas of varying sizes, largest 5 mm. in diameter. In apex of upper lobe is a cavity about 1 cm. in diameter, containing caseous material.

Lt. Lung: 800 gms. Upper lobe firm and infiltrated with spherical areas of dense grayish-red tissue. In general lung is mottled with slightly raised grayish areas varying from pinhead size to 4-5 mm. in diameter. The larger areas reach a diameter of 7.5 cm. Lower lobe of same general character. In mid portion of lower lobe, and toward root of lung, is a very large cavity, bilocular, measuring 7 x 6 cm. in greatest diameter. The peribronchial nodes are somewhat enlarged.

Pericardial Cavity: Small amount of clear serous fluid.

Heart: 250 gms. T. V., 11 cm.; P. V., 6 cm.; R. W., 4 mm.; R. C., 7 cm.; M. V., 8 cm.; A. V., 7 cm.; L. W., 2 cm.; L. C., 9 cm.

Heart muscle normal. Thoracic aorta smooth. Right ventricle contains clot which is well moulded and branched, main part measuring 5 cm. in length, with the two branches 7 cm. Left descending coronary patent; slightly thickened on one periphery.

Abdominal Cavity: No fluid, no adhesions.

Spleen: 275 gms. 15 x 9 x 3 cm. Substance soft and follicles very prominent.

Rt. Kidney: 150 gms. 13 x 6 x 2.5 cm. Markings very distinct; very similar to other kidney.

Lt. Kidney: 175 gms. 12 x 5 x 2.5 cm. Markings distinct.

Adrenals: About same size and appearance; each shows little central cavitation.

Pancreas: Grossly normal.

Liver: 2200 gms. 25 x 17 x 11 cm. Consistency normal; color dusky.

Gall Bladder: Contains large oval stone, 2.5 x 1.5 cm.

Intestines: Normal.

Bladder: Normal.

Genitalia: Protruding from fundus of uterus is a pedunculated nodular fibroid tumor 6 cm. in length. Tubes and ovaries present and normal. Uterus normal on section, but on anterior aspect is a subserous tumor.

Cranial Cavity: Not opened.

Anatomical Diagnosis:*

1. Pulmonary embolism.
2. Pulmonary tuberculosis, with cavitation of left lower lobe and fibrosis of right lung.
3. Cholelithiasis.
4. Uterine fibroid.
5. Thrombosed varicose veins in both legs.

Microscopic Examination:

Spleen: Near capsule one solitary tubercle was found, without giant cells.

Lungs: Caseous tuberculosis.

Liver: Small focal scattered granulomata, consisting of epithelioid cell reaction with lymphocytes; no giant cells.

Tumor: Fibromyoma of uterus.

Kidney: Moderate arteriosclerosis with some scarring and obliteration of occasional glomeruli.

Pancreas: Appears normal, except for small hyalinized areas, the significance of which I do not know.

Summary: As Anatomical Summary, except for solitary tubercles in spleen and liver.

* Reference: "Thrombosis: A Medical Problem"—Mead Burke: *Amer. Jour. of Med. Sciences*, 196: 6: pg. 796, Dec., 1938.

Comment

(E. R. Blaisdell, M. D.)

In reviewing this case, it seemed to me that the outstanding features were: the coexisting diabetes and pulmonary tuberculosis, the 0 sedimentation rate in the presence of a "destructive" type of tuberculosis, and sudden death from pulmonary emboli in a patient who showed at autopsy multiple venous thrombi of the legs.

The presence of tuberculosis and diabetes in the same patient is not uncommon and the response to treatment is, in most instances, usually good. In many clinics, X-ray examination of the chest is a routine procedure in all diabetics. During the past two years, this has been done in the majority of service diabetic patients at the Maine General Hospital.

I am unable to explain the 0 blood sedimentation rate. There is no record of the test having been repeated in this patient. One would naturally expect that rate to be increased in the presence of the amount of tissue destruction that was found at the postmortem table. Certainly, there should have been enough exudative absorption to influence the rate.

The pathological report makes no mention of dissection of the lower extremities. However, presumably there were also thrombi in the deep veins as emboli from superficial veins are rare.

Sudden death from a pulmonary embolus is, unfortunately, not infrequent following pelvic surgery and hernia operations. Medical patients are likewise not immune from such a catastrophe. Death does not necessarily follow a pulmonary embolism, and both the roentgenologist and pathologist have taught us that unexplained chest pathology in both medical and surgical patients is frequently due to pulmonary infarction. This brings to my mind an important question. Is

our present custom of keeping medical patients who are suffering from chronic disease completely at rest a proper procedure? Surgeons have, for a long time, advised bed exercises for the postoperative patient,—while medical patients, frequently not acutely ill, are kept constantly in bed during a long illness. Should we be less rigid and, for example, allow the patient who is satisfactorily convalescing from congestive heart failure to walk a few steps to the toilet for a daily bowel evacuation? By so doing, it has occurred to me that we might decrease the incidence of pulmonary embolism in medical patients.

The Toxemias of Pregnancy and Electrolytes

A most valuable presentation of this subject was made by McPhail of the Great Falls Clinic, Montana, before the Section on Gynecology and Obstetrics, A. M. A., June 15, 1938. In the past few years remarkable clinical studies have developed most important facts regarding water balance, acid-base equilibrium, renal function and shifts in body water and electrolyte. At our meeting at Belgrade we had the opportunity to hear Frederick Coller, Professor of Surgery at the University of Michigan, present a most instructive and valuable paper on original work done on this subject. The paper by McPhail deserves to be read and studied by all who are actively engaged in obstetric work, it appears in full in the Journal of the American Medical Association, November 19, 1938.

The following summary expresses briefly the clinical observations based on two thousand obstetric cases under the care of the author.

Table 2.—*Summary of Maternal and Infant Mortality for Toxemias of Pregnancy in Cases in Which the Infant Reached a Period of Viability*

Date	Antepartum Observation	Cases	Infants	Maternal Mortality	Infant Deaths and Still Births	Infant Mortality, Percentage
Nonconvulsive, All Types						
1931-1935 1,000 deliveries; treatment conservative	Yes	45	46	0	3	6.5
	Not treated until toxemia was severe	7	8	0	3	37.5
1935-1938 1,000 deliveries; treatment, forced fluids, neutral diet	Yes	53	54	0	1	1.8
	Not treated until toxemia was severe	6	7	0	4	57.0
Convulsive Type						
1931-1935	Yes	2	2	0	0	0
	Not treated until toxemia was severe	4	6	0	2	33.3
1935-1938	Yes	0	0	0	0	0
	Not treated until toxemia was severe	0	0	0	0	0

Summary

1. The toxemias of pregnancy occur in women with some previous impairment of renal function. This impairment leads to a gradual retention of urinary waste and electrolyte.

2. Retention of urinary solids leads to dehydration of all the cells of the body and the fetus. Dehydration alters the function of the cells and accounts for metabolic changes in the various organs of the body.

3. Retention of electrolyte is responsible for the different types of toxemias. A diet yielding an alkaline ash leads to retention of alkaline ions and the development of cellular dehydration in the presence of edema. A diet high in acid ash leads to retention of acid ions with general dehydration of all cells.

4. The toxemias may be prevented by the ingestion of large quantities of fluid and a neutral diet low in sodium if treated early, or they may be controlled at any time if treated before severe cellular damage has resulted.

5. The infant mortality for the toxemias of pregnancy can be lowered.

The President's Page

To the Members of the Maine Medical Association:

Unfortunately, during the last decade there has been a growing tendency on the part of the members of our profession to forget the honor and dignity bestowed upon them when the letters M. D. were affixed to their names and through carelessness they have allowed the prefix Dr. to take its place.

Surely they have not forgotten that day in June so many years ago, when clothed in flowing gowns, surrounded by friends and relatives, they were presented with a sheepskin by one of the members of their faculty which signified that they had completed four long years of study devoted to the Science of Medicine, and as a result of their diligence and perseverance, had honestly earned the degree of Doctor of Medicine.

The members of our profession must agree that the prefix Dr. has lost its significance and when placed upon the office door, letterhead or prescription pad, affords us no mark of distinction, while the letters M. D. affixed to our name place us in an exclusive category indicative of that high type of education which is demanded of us before we are entitled to the degree of Doctor of Medicine.

We are the custodians chosen to care for the ills and medical calamities confronting the people of our country, and this being true, let us strive at least to maintain our dignity to the extent of designating by the letters M. D. that we are followers of the medical profession and avoid the prefix Dr., which unfortunately does not even imply that we have in any way acquainted ourselves with the elementary principles of medicine.

Willard H. Bunker, M. D.,
President Maine Medical Association.

Editorial

The Woman's Field Army and the Cancer Clinics

At a recent meeting of the advisory board of the Woman's Field Army of Maine certain definite and important facts were brought out which it is desired to place before the medical profession of the State.

When the Woman's Field Army started its work in 1937 the cancer clinics of the State were poorly attended and were far from organized and staffed on their present basis. We were also faced with the fact that some patients suitable for X-ray and radium treatment, some of whom probably could have been greatly benefited if not relieved entirely, could not be so treated since sufficient funds were not available.

As a result of the 1937 spring membership drive some $6,000.00 was made available to the clinics for diagnosis, X-ray and radium treatments for a certain referred group of patients. As a direct result of this contribution a rapid demand for the service ensued so that by the first of September, 1938, all funds that had been allocated for this purpose were entirely used up.

These facts strongly emphasize two things:

1. The value of and the direct results obtained from educational efforts, which brought increasingly large numbers of cases to the clinics each month and,

2. The need of more funds to carry on the expense of X-ray and radium treatment and to improve the quality of the service rendered. That it is utterly impossible, also unfair, to feel that all indigent cancer patients can or should be taken care of through funds raised by the Woman's Field Army must be obvious.

The problem of how to best handle this situation has given the State Advisory Board no little concern and many long hours of discussion have been spent in an endeavor to reach a solution which shall bring the greatest benefit to the indigent cancer patient and yet be fair to the hospitals handling these clinics. The Board feels very strongly that the rapid growth of the clinics, also the demand on the part of the public for more funds for treatment, has very definitely demonstrated the value and the need of the clinics as permanent parts of the State aid to the sick.

The situation in Maine differs from that in such States as Massachusetts and others, which maintain hospitals for the exclusive care of the cancer patient. It must be understood, however, that with the allotment of an increased appropriation of funds for State aid to hospitals this coming year, the Legislature is unwilling and justly so to ear mark any part of the appropriation for "cancer treatment alone."

We can point with justifiable pride to the work of the Woman's Field Army in Maine as it is the only army so far in the United States to provide both for education and treatment of cancer patients. It should be understood by everyone that this contribution to treatment was an entirely voluntary one—there was no legal obligation—and it ceased only when—and because—the funds raised were inadequate to meet the rising demands of the rapidly growing clinics. It should also be understood that as funds become available to the Field Army, over and above what is necessary for educational purposes, they will again be contributed towards treatment.

We believe that education is of prime importance. That it has been eminently successful in Maine is evident by the rapidly growing number of patients seeking advice at the clinics. It is the intention of the Woman's Field Army to carry on a vigorous campaign again this coming Spring, both for educational purposes and for further funds with which to defray the expenses of the increasing clinic demands.

Piscataquis Scores Again

To Piscataquis County Medical Society, for the second successive year, goes credit for being first to send in to the Maine Medical Association office 100% payment of 1939 dues. Check covering all members was received on January 4, 1939.

Panel Discussion on Pneumonia

The York County Medical Society, under the auspices of the Committee on Graduate Education, presented a most valuable and interesting panel discussion on pneumonia at a meeting held in Scarboro on January 4th. It would certainly seem that this sort of a program, on many subjects, offers a great deal in graduate educational efforts. It brings to the members the experience of those skilled and interested in the different topics they have assigned and what is even of more importance, invites free discussion from the audience. It seems to your Graduate Educational Committee that such programs surpass in many ways the didactic type of paper too frequently presented. Any County Society that cares to have this program on pneumonia can ascertain the available dates from Dr. Frederick T. Hill, Chairman, Waterville. Every effort will be made to provide a time agreeable if the committee can have sufficient advance notice. As time goes on the committee hopes to have definite and stated panel discussions available on other important medical and surgical subjects and it will during the winter months gladly provide one on any subject that is called for provided it can have sufficient time to obtain the personnel required.

The following physicians comprised the panel:

Chairman: Frederick T. Hill, Waterville.

History and Examination: T. E. Hardy, Waterville.

Pathology: Julius Gottlieb, Lewiston.

X-ray Diagnosis: Langdon T. Thaxter, Portland.

Cardiac Complications: E. H. Drake, Portland.

Surgical Complications: S. A. Cobb, Sanford.

Medical Treatment: E. R. Blaisdell, Portland.

Financial Grants for Cancer Research

Financial grants for cancer research in designated hospitals and medical colleges was considered by the National Advisory Cancer Council at its all-day meeting January 3 at the National Institute of Health.

Surgeon General Parran, who is ex-officio chairman of the Council, also said the Council will discuss policies regarding the training of specialists in various phases of cancer work and plans for increasing public knowledge concerning cancer symptoms and the necessity for early treatment.

Reports will be presented by Dr. Ludvig Hektoen, executive director of the National Advisory Cancer Council, and Dr. Carl Voogtlin, Chief of the National Cancer Institute. Distribution plans for the $200,000 shipment of radium which arrived in Washington two weeks ago will be included in the reports. The 91½ grams owned by the institute are now being tested at the Bureau of Standards. Within the next two months most of this radium will be loaned out in small quantities to hospitals, cancer clinics and medical centers, in acordance with regulations approved by the Council at its October meeting.

The meeting was the first attended by Dr. Mont R. Reid, director of Surgical Service, Cincinnati General Hospital and Professor of Surgery at the University of Cincinnati, and Dr. James Murphy, Chief of the Cancer Research Division of the Rockefeller Institute, New York, who were chosen last month as new members of the Council for three-year terms.

Continuing members of the Council who were present at the meeting included President James B. Conant of Harvard University, who is an authority on chemistry; Dr. Arthur H. Compton of the University of Chicago, a Nobel prize-winner in physics; Dr. C. C. Little, Managing Director of the American Society for the Control of Cancer;

and Dr. Ludvig Hektoen, of Chicago, former director of the John McCormick Institute for Infectious Diseases, who is serving as executive Director of the National Advisory Cancer Council.

Dr. Hektoen, as executive director, commented on the recent grant to Meharry Medical College of Nashville, Tennessee, for the support of its cancer clinic, and the new developments in connection with the cyclotron, the atom-smashing machine set up in the California Institute of Technology. He presented the opinions expressed by the deans of medical schools and officers of the American Board of Surgery and the American Board of Radiology, concerning the training of cancer specialists.

County News and Notes

Androscoggin

The annual meeting of the Androscoggin County Medical Society was held January 19, 1939.

Minutes of the last meeting were approved as read. A preliminary report on the T. B. Association work was given by Dr. Russell. A full report on the treasury will be given at the next meeting.

Report of the Secretary-Treasurer approved as read.

Dr. Dupras raised the question regarding commercial telephone rates at medical residences. Following discussion, a motion was made by him, and carried, that a committee comprising the incoming President and Secretary look this up for the next meeting.

The President nominated Drs. Russell, Higgins and Fahey as a Nominating Committee for Officers for the ensuing year.

The following officers were elected:

President, L. P. Gerrish, M. D.

Vice-President, John C. Cartland, M. D.

Secretary-Treasurer, Wedgwood P. Webber, M. D.

3rd Council Member, H. L. Garcelon, M. D.

Delegates to the Annual Session of the Maine Medical Association, D. F. D. Russell, M. D., and L. A. Sweatt, M. D.

Public Relations Committee, S. L. Andrews, M. D., R. A. Beliveau, M. D., M. J. Harkins, M. D.

This was followed by a short discussion by the retiring President regarding present-day medical relationships and possible tendencies.

A. E. Peters, M. D., *Secretary.*

Hancock

The annual meeting of the Hancock County Medical Society was held on November 30, 1938.

The following officers were elected to serve during the year 1939:

President, G. A. Neal, M. D., Southwest Harbor.

Vice-President, R. B. Coffin, M. D., Southwest Harbor.

Secretary-Treasurer, M. A. Torrey, M. D., Ellsworth.

Delegate to the Annual Session of the Maine Medical Association, M. A. Torrey, M. D., Ellsworth.

Alternate, J. H. Crowe, M. D., Ellsworth.

Censors: R. W. Wakefield, M. D., Bar Harbor (three years); Edward Thegan, M. D., Penobscot (two years); Philip Gray, M. D., Brooksville (one year).

G. A. Neal, M. D., *Secretary.*

Knox

The annual business meeting of the Knox County Medical Society was held December 27, 1938, at the Copper Kettle, Rockland. Doctors Gilmore Soule of Rockland and John B. Curtis of Thomaston were admitted to membership by approved applications, and Dr. Bousfield of North Haven was transferred from Hancock County Medical Society.

The approaching clinic of the Red Cross for diphtheria immunization was approved, and the doctors' services volunteered.

Dr. Appollonio gave a very interesting short talk on his trip with MacMillan to Labrador and Greenland, reviewing his medical findings.

Officers elected were:

President, Howard Apollonio, M. D., Camden.

Vice-President, Charles B. Popplestone, M. D., Rockland.

Secretary-Treasurer, A. J. Fuller, M. D., Pemaquid.

Board of Censors, Alvin Foss, M. D., Rockland.

Delegates to the Annual Session of the Maine Medical Association: Howard Apollonio, M. D., and A. J. Fuller, M. D.

Alternates: Gilmore Soule, M. D., and John B. Curtis, M. D.

The next regular meeting is scheduled for February 14th.

A. J. Fuller, M. D., *Secretary.*

Penobscot

The regular monthly meeting of the Penobscot County Medical Association was held Tuesday, December 20, 1938. Guests of the Association were Dr. W. H. Bunker, President of the Maine Medical Association, and Dr. Channing Frothingham, President of the Massachusetts Medical Association. Dr. Frothingham conducted a medical clinic at the Eastern Maine General Hospital during the afternoon.

Following dinner at the Bangor House at 7 P. M., a group of 61 interested physicians listened to the speakers of the evening. Dr. Bunker presented some of the problems which confront the Maine Medical group, and his remarks elicited long and lively discussion from the floor. Dr. Frothingham chose for his subject "Economic Problems in Medicine," stressing especially the need for concerted and coördinated effort by the medical profession to meet the challenge from the laity at the present time. Some proper form of insurance was advocated by the speaker.

J. Robert Feeley, M. D., Resident Surgeon at the Eastern Maine General Hospital, was elected to membership.

Forrest B. Ames, M. D., *Secretary.*

Norman W. Loud, M. D., A. B. R. in Diagnostic Roentgenology, has recently joined the Staff of the Eastern Maine General Hospital as Associate Roentgenologist.

York

The annual meeting of the York County Medical Society was held at the Normandie, in Scarboro, January 4, 1939, at 2 o'clock, preceded by a dinner.

Election of officers followed, the nominating committee consisting of Drs. Dolloff, Perrault and Paul Hill, Jr.

Officers elected were:

President, Dana B. Mayo, M. D., South Eliot.

Vice-President, W. T. Roussin, M. D., Biddeford.

Secretary - Treasurer, C. W. Kinghorn, M. D., Kittery.

Board of Censors: S. A. Cobb, M. D., Paul Hill, Jr., M. D., and E. C. Cook, M. D.

Delegates to the Annual Session of the Maine Medical Association: S. A. Cobb, M. D., and C. W. Kinghorn, M. D.

Alternates: W. H. Kelly, M. D., and J. H. MacDonald, M. D.

Reports were read and accepted.

Doctors Hill, Dolloff and Dennett were appointed as a committee to draw up resolutions on the deaths of Doctors Randall and Weeks.

Doctors Hill and MacDonald were appointed to take charge of the April meeting to be held at Kennebunk, Maine.

W. L. Morse, M. D., of Springvale was elected a member of the Society.

Following the business, the meeting was given over to the Chairman, Frederick T. Hill, M. D., of Waterville, who conducted a Panel Discussion on Pneumonia. The topics were:

Examination and History, T. E. Hardy, M. D.

Surgery, S. A. Cobb, M. D.

Heart, E. H. Drake, M. D.

X-ray, Langdon Thaxter, M. D.

Pathology, Julius Gottlieb, M. D.

Medical and Summary, E. R. Blaisdell, M. D.

This Panel Discussion, which will be sponsored by the Maine Medical Association, during the year, will later appear in the Journal of the Maine Medical Association.

A record on dues was established at this meeting, as there was a hundred per cent payment on all those present.

C. W. Kinghorn, M. D., *Secretary.*

New Members

Knox

Gilmore Soule, M. D., Rockland.
John B. Curtis, M. D., Thomaston.

Penobscot

J. Robert Feeley, M. D., Bangor.

York

W. L. Morse, M. D., Springvale.

Coming Meetings

Kennebec

Kennebec County Medical Association, Frederick R. Carter, Augusta, Secretary.

February 16, 1939, at the Elmwood Hotel in Waterville, Maine. Panel Discussion—*Pneumonia.*

March 16, 1939, at the Augusta General Hospital.

April 20, 1939, at the Gardiner General Hospital. Speaker: Samuel Levine, M. D., Boston. Subject: *The Ausculation of the Heart.*

May 18, 1939, at the Veterans' Administration at Togus, Maine.

Knox

Knox County Medical Society, A. J. Fuller, M. D., Pemaquid, Secretary.

The next meeting of the Knox County Medical Society, with Dr. H. L. Apollonio, President, will be held Tuesday, February 14th, at 7.00 P. M., at the Copper Kettle, Rockland, Maine.

The guest speaker of the evening will be Dr. Everett D. Kiefer, of the Lahey Clinic, who will speak on *The Management of Ulcerative Colitis and Functional Colonic Disorder.* Dr. Clapp of Lewiston will discuss this paper.

Necrologies

Francis O. Hill, M. D.

Dr. Francis O. Hill, 65, of Monticello, died at his home January 2nd, after an illness of some four years. Dr. Hill graduated in medicine from Bowdoin Medical College in 1899 and for a year was associated with an uncle, Dr. F. O. K. Hill of Brewer. He came to Monticello in 1900 and for many years carried on an extensive country practice. He was a past president of the Aroostook County Medical Society, served as a member of the Maine Legislature in 1907 and during the world war was a Member of the Medical Advisory Board for southern Aroostook.

Robert J. Kincaid, M. D.

Dr. Robert J. Kincaid, 75, for 44 years a practitioner in Mars Hill, died at his home in that town on January 1st. Dr. Kincaid was a member of the Aroostook County Medical Society and for many years was a prominent and well-known practitioner in Aroostook County. He graduated in medicine from Bowdoin Medical College in 1891 and with the exception of three years in Washburn and one year in Somerville, Massachusetts, lived and practiced in Mars Hill.

Notices

American Medical Association Council on Physical Therapy

The American Medical Association has a number of motion picture films for loan, among which are several on Physical Therapy. The borrower is expected to pay the expense both ways and is expected to be careful when running them.

Dr. Thomas G. Hull, Director, Scientific Exhibit, 535 N. Dearborn Street, Chicago, Illinois, has charge of the distribution.

HOWARD A. CARTER, *Secretary.*

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*Tumor Clinics**

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 10.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital*—Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital—Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Announcement

The American Board of Ophthalmology announces an important change in its method of examination of candidates for the Board's certificate.

Examinations will be divided into two parts. Candidates whose applications are accepted will be required to pass a WRITTEN examination which will be held simultaneously in various cities throughout the country approximately 60 days prior to the date of the oral examination.

Only those candidates who pass the written examination and who have presented satisfactory case reports will be permitted to appear for the oral examination.

Examinations scheduled for 1939: WRITTEN: March 15th and August 5th. ORAL: St. Louis, May 15th; Chicago, October 6th.

Applications for permission to take the written examination March 15th must be filed with the Secretary not later than February 15th.

Application forms and detailed information should be secured at once from Dr. John Green, Secretary, 6830 Waterman Ave., St. Louis, Mo.

Book Reviews

"Practical Microbiology and Public Health"

By William Barnard Sharp, S. M., M. D., Ph. D., Professor of Bacteriology and Preventive Medicine in the Medical Department of the University of Texas; Visiting Bacteriologist of John Sealy Hospital, Galveston; Supervisory Bacteriologist of Galveston Health Department.

Published by The C. V. Mosby Company, 1938, St. Louis. Price, $4.50.

This handbook is so designed as to aid the medical student in organization, interpretation, and systematic recording of data from the field as well as from the laboratory. It is divided into eight parts. Each part contains the working schedule for the various fields to be investigated. The subject matter is so arranged that it can be made to serve parallel with the didactic and practical work usually performed in the medical curriculum. The book covers not only bacteriology but subjects related to public health as well. The working schedules are of sufficient elasticity to permit of their adaptation to courses of varying lengths.

"Cancer—With Special Reference to Cancer of the Breast"

By R. J. Behan, M. D., Dr. Med (Berlin), F. A. C. S., Cofounder and Formerly Director of the Cancer Department of the Pittsburgh Skin and Cancer Foundation, Pittsburgh, Pa. Published by The C. V. Mosby Co., St. Louis, 1938. Price, $10.00.

Cancer in general is demanding a great deal of the time and effort of the medical profession both in the field of action of the general practitioner as well as in the fields of all the specialties. Cancer of the breast, especially of the female breast, is a very large and important special field within the all-comprehensive field of pathological new-growths commonly designated by the term "cancer." The author of this treatise begins with the exposition of the various characteristics of cancer in general, then limits his attention to the extensive description of the characteristics of cancer of the breast. He then goes thoroughly into the various methods of treatment, operative, constitutional, irradiative, etc. Though no ideal specific test has yet been discovered but because some tests have been devised in the hope of eventually making earlier diagnosis possible, the author reviewed many of the more promising tests for cancer. This is in accordance with his desire to make the book under review a complete unit. Those tests which have received most favorable recognition by the authoritative students of cancer are described in detail. The one hopeful factor in prognostic value seems to be that in all of the published statistics on cancer, where the correct diagnoses are made early and where the appropriate and most expert operative and irradiative treatment was instituted at once, fatal metastasis could be considerably reduced and life greatly lengthened.

Concerning treatment, the author writes: "Cancer is the most difficult and complex of all diseases to understand and its treatment demands an almost universal knowledge of medicine and of physics. Therefore, it seems logical to conclude that the cancer patient can be most effectively treated by those who have made a special study of cancer." He devotes more than 350 pages to the exposition of various forms of treatment which have been found to be more or less successful by many expert and careful specialists in cancer therapy.

"Twenty-Eight Years of Sterilization in California"

By Paul Popenoe, Sc. D., and E. S. Gosney, B. S., LL. B., President of the Human Betterment Foundation. Published by the Human Betterment Foundation, Pasadena, Calif. Price, 25c.

The study of this little publication seems almost to transmit to the reader the enthusiasm with which the authors describe the work done by many workers in accordance with the California eugenic sterilization law. They claim that eugenic sterilization has progressed beyond the experimental stage. They seem to be convinced that "It is the consensus of opinion of students of the subject from a social and scientific viewpoint, that all evidence justifies sterilization as one of the indispensable measures that must be included in any fundamental and humanitarian progress for dealing with society's increasing burden of mental disease, deficiency and dependency." However, the medical profession as a whole, better than any other profession, knows that the factors which

combine to form the foundations upon which the structures of mental disease, deficiency, and dependency develop, are extremely complex in nature and very difficult to discover. The problems which present themselves can but rarely be successfully solved by such over-simplified therapeutic measures as the practice of active eugenic sterilization presents.

"You Can Sleep Well—The A B C's of Restful Sleep for the Average Person"

By Edmund Jacobson, M. D. Published by Whittlesey House, New York, London. McGraw-Hill Book Company, Inc., 1938. Price, $2.00.

Modern men and women, living through their days in restless activity, seem to have lost the instinct to relax in order to enjoy restful, refreshing sleep during the oncoming night, which instinct is naturally present in the child. The author of the book under review enumerates some of the many improper methods we all are apt to try at one time or another for the purpose of promoting relaxation and inducing restful sleep. Considerable space is used for the description of his six steps of "How to Sleep Well." Two chapters are devoted to the laboratory methods of studying and measuring sleep under scientifically controlled conditions. The present work is an attempt to present to lay readers, in simplified language, the results of the author's relaxation or rest method, developed and employed by him during the past thirty years, for the purpose of producing refreshing, restful sleep by means of very simple exercises.

"Biography of the Unborn"

By Margaret Shea Gilbert. Published by The Williams & Wilkins Company, Baltimore, 1938. Price, $1.75.

The author possesses the rare and remarkable gift to be able to tell that part of man's life story which has baffled man's mind through all the centuries of historic evolution, and which still stimulates the scientific man's mind of today to further research in a most charming manner. The life of the world's greatest, as well as that of the world's lowliest man, as it is lived from the moment of conception to the moment of birth, hidden away from the investigating eyes of the experimenter, far removed from the turmoils which torture the living, within his mother, is now told in a language which every man and woman of average intelligence can understand.

This part of the story of man's progress in evolution as told by the biographer of the unborn becomes increasingly fascinating when it is understood that "ever since ancient times men have conjectured and debated about the manner in which human life is started, and the means or events through which the child takes form within the mother." When it is further understood that "the fact that sexual relationship always precedes the creation of a child was perhaps the only real

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Art Tells History of American Medicine

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"Beaumont and St. Martin" is the first of six large paintings in oil memorializing "Pioneers of American Medicine" which artist Dean Cornwell will complete in the next few years. Others in the series are: Dr. Oliver Wendell Holmes, Dr. Ephraim McDowell, Dr. Crawford W. Long, Dr. William T. G. Morton, and Major Walter Reed, and one woman, Dorothea Lynde Dix, who, while not a physician, stimulated physicians to study insanity and feeblemindedness.

Arrangements to supply physicians with free, full color reproductions of "Beaumont and St. Martin" without advertising, and suitable for framing, have been made with the owners, John Wyeth and Brother, 1118 Washington Street, Philadelphia.

information available to the early Greek philosophers," but that "not until the nineteenth century did men finally realize that the union of the sperm and the egg creates a new human being," the "Biography of the Unborn" becomes most instructive reading. It is scientific literature of high degree. In addition, it is a masterpiece in literature which is accepted by well-known authorities.

"Medicine in Modern Society"

By David Riesman. Published by the Princeton University Press, Princeton, 1938. Price, $2.50.

This is a pleasingly written and highly instructive epitomization of the history of medical progress. In less than 225 pages the author spreads out before the reader's eyes the many centuries during which man has tried to evolve ways and methods by means of which he could reduce or abolish his own suffering as well as that of his fellow human beings. In stylishly attractive and readily understandable language, the march of progress in the medical sciences is traced through some 3,500 years of human efforts at civilization. By presenting and elaborating on the work of the various outstanding personalities of the several epochal periods of progress made in several countries, the author provides the physician as well as the intelligent layman with easily accessible data by which may be measured man's success at solving some of the complex problems which present themselves daily in most everyone's life. The lessons taught by the master minds of antiquity are then skillfully adapted to the needs of our present-day requirement in our more highly complicated civilization. The American way of solving our own problems is highly recommended but it is shown that greater progress of a more lasting quality can be expected if more attention is paid in the future to the lessons taught by the errors made in the past.

"Drug Addicts Are Human Beings"

By Henry Smith Williams, M. D., B. Sc., LL. D. Published by the Shaw Publishing Company, Washington, D. C., 1938. Price, $2.50.

When a man has written more than one hundred books, the one under review being the author's one hundred and nineteenth, even a fault-finding reviewer could not retard the progress of such a dynamic personality.

In the present volume Dr. Williams presents for the first time the truth as he sees it concerning the origin and development of the Narcotic Code. He shows by way of documentary evidence the almost unbelievable cruel workings of one of America's great industries, the "Illicit Drug Traffic," also called "dope" racket or "billion-dollar racket." The purpose of the book is the full exposition of the shameful and humiliating record of this enterprise.

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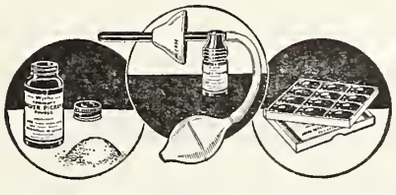

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"Feminine Hygiene in Marriage"

By A. F. Niemoeller, A. B., M. A., B. S. Author of American Encyclopedia of Sex, Men Past Forty, etc. Published by Harvest House, New York, 1938. Price, $2.00.

A clear common sense presentation of common problems told in common sense language to the common people is always a welcome addition to the rapidly growing semi-scientific lay literature. The problems of female sexuality are taken up progressively and discussed. If common sense solutions are known, they are named. If medical remedies are needed they are indicated. Self-medication is strongly advised against. When abnormal functioning of the female genito-urinary system is encountered, the reader is most strongly advised to consult her physician. The book is primarily addressed to the married woman and its purpose is to promote her health and marital happiness, and is based upon the common knowledge that many wives are rather careless in their practice of feminine hygiene. "The book is intended only to help the woman in the daily personal and intimate care of herself and is not to be considered a manual for the self-treatment of disease or disease conditions."

"How to Conquer Constipation"

By J. F. Montague, M. D., Editor-in-Chief of *Health Digest* Medical Director, New York Intestinal Sanitarium; American Association for the Advancement of Science; American Society for the Control of Cancer; Late of University and Bellevue Hospital Medical College; Fellow American Medical Association; Fellow New York Pathological Society; Sometime Fellow New York Academy of Medicine and American College of Surgeons.

Published by J. B. Lippincott Company, Philadelphia, 1938. Price, $1.50.

This small volume tries to present to the lay reader what is wise and otherwise in dealing with the problem of so-called constipation. The author describes in simple language simple methods by the application of which the apparently ever-present question: What shall I do about it? can be pragmatically answered in most instances. When doubtful situations arise or where pain, general and lasting discomfort, fever or hemorrhage are troubling symptoms, the author strongly advises his readers to consult the family physician who may then consult the proper specialist if this should become necessary.

"Synopsis of Clinical Laboratory Methods"

By W. E. Bray, B. A., M. D. Professor of Clinical Pathology, University of Virginia; Director of Clinical Laboratories, University of Virginia Hospital.

Published by The C. V. Mosby Company, St. Louis, 1938

Due to the many advances in clinical laboratory methods during the last two years, the author found it necessary to put a new edition of this pocket book synopsis into circulation. A great many new procedure descriptions have been added. Even though these descriptions are purposely brief in order not to increase the size of the book too much, the directions given are considered quite adequate for successful performance of the various tests if they are closely followed.

"The Practice of Medicine"

By Jonathan Campbell Meakins, M. D., LL. D., Professor of Medicine and Director of the Department of Medicine, McGill University; Physician-in-Chief, Royal Victoria Hospital, Montreal; Formerly Professor of Therapeutics and Clinical Medicine, University of Edinburgh. Fellow of the Royal Society of Edinburgh; Fellow of the Royal Society of Canada; Fellow of the Royal College of Physicians, London; Fellow of the Royal College of Physicians, Edinburgh; Honorary Fellow of the Royal College of Surgeons, Edinburgh; Fellow of the Royal College of Physicians, Canada; Fellow of the American College of Physicians.

Published by The C. V. Mosby Company, St. Louis, 1938. Price, $12.50.

Among America's best one-volume textbooks, "Meakins" certainly deserves an honorable position. Quite correctly the author elaborates more upon the great many varieties of those diseases

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and their symptoms and treatment which are not ordinarily accessible in all the medical centers during the young doctor's training in school as student, or in the hospital as interne. The frequently-occurring diseases impress themselves readily enough during these formative years as memorable experiences. It is those rarely seen cases which frequently confront the general practitioner, especially in times like the present, where the exchange of labor between the various states and various nations is so widely practiced, which the author brings before the reader. It frequently happens that apparently healthy migrants come from territories where certain epidemic or endemic diseases circulate freely. To be able to recognize the first sporadis case in one's community often prevents a serious spread. A great many of the excellent illustrations incorporated in this text are so clearly illustrative of such cases which are more or less unusual in everyday practice that the disease suspected can be readily recognized when patient and physician meet.

The material contained in "Meakins" is reliable, the remedies recommended have been tried in actual practice, modern discoveries have been included if found practicable, functional pathology is properly evaluated, and sub-clinical aspects are clarified whenever this was possible.

"Clinical Laboratory Methods and Diagnosis"

By R. B. Gradwohl, M. D. Published by C. V. Mosby Company, St. Louis, 1938. Price, $12.50.

"Gradwohl" is positively the most monumental creation of its kind so far produced in the Americas as far as this reviewer has been able to ascertain. That the author intends to keep the subject of clinical laboratory methods and diagnosis fully alive and abreast with the times is fully evidenced by the fact that after three short years he found it necessary to thoroughly revise his first work. It seems that almost every task can be handled successfully with the help of the present text. The two largest sections, hematology and helminthology received considerable revisorial attention.

It must be considered most beneficial to physicians everywhere that such a far-reaching field as Parasitology and Tropical Medicine presents was elaborated so remarkably well with the collaboration of Professor Pedro Kouri of the Medical School of Havana, Cuba. Americans like to travel and travel within the Americas exposes them to the various disease-producing organisms that prevail somewhere on our hemisphere. Professor Kouri shows with most excellent microphotographs all of the distinguishing characteristics of the more common tropical and subtropical parasites. Almost three hundred pages are devoted to this and allied subjects. More than a hundred pages have been added to the chapter of hematology, making a total of four hundred twenty-seven pages. Complete data on the various theories of blood development are given. Twenty-four full page color plates have been added. Forty-six varieties of blood cells are described. The Schilling theory is more thoroughly elaborated.

It is a magnificent work, and when the diligent and faithful worker has overcome a certain feeling of awe which may come over him for a moment when he is confronted by the wealth of useful information and the multitude of tests by means of which further information must be laboriously obtained in the name of scientific medicine, he will find "Gradwohl" to be his most reliable consultant.

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The Journal of the Maine Medical Association

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*The Doctor's Dilemma When and If the Government Goes Into the Practice of Medicine in a Big Way**

By Roger I. Lee, M. D.,† Boston, Mass.

Many of the laity and indeed many of the Doctors are wondering what is behind all this tremendous discussion about the medical profession. The terms used are often confusing: State Medicine, Socialized Medicine, etc. The hall-room boys, who write signed and solemn articles about this, that and the other, declare that the American Medical Association has been too conservative in its leadership. The sob sisters write harrowing tales of drunken fathers and destitute families. The villain of the piece seems to be the doctor. The heroine is the social worker and the hero is the young handsome politician who has studied economics and sociology and who has been elected on a reform platform of complete, perfect and free medical service for all and d—— the expense. The idea is naturally intriguing. For after all it is the payment for the necessities of life that hurts. The idea of only paying for life's luxuries has real allure. And so we have studied the costs of medical care and discovered that the people of this country pay more for their cosmetics, their candies, and their patent medicines than they do for their medical care. Then the doctors got busy with their Medical Economics and vociferously claimed that socialized medicine is only state medicine, and words fail to describe what might happen when the government goes into the practice of medicine.

But at this juncture some people get up and say, "And so what!".

And then this past summer there was a so-called Health Conference. At this Conference before a carefully picked and packed audience, the report of the Interdepartmental Committee on Health, appointed by the President, was read. After this reading, the report was sent to the President, and now it has been sent by him essentially without recommendations except for careful consideration as a Message and as a Health Program to Congress.

The document starts out with obvious errors of fact as to the existing health and medical services in the United States. Upon this erroneous presupposition is built up the theory that if there is enough money ex-

* Read before the Cumberland County Medical Society, Portland, Maine, January 27, 1939.
† Trustee: American Medical Association.

pended, a health utopia will be attained. The early yearly costs of the program will come to $850,000,000 a year for certain parts of the program and perhaps a total cost of nearly $5,000,000,000 a year for the full program. Actually, the five proposals are in no sense a health program, but proposals for government expenditures not only for preventive medicine and public health but also for those medical services which are concerned solely and exclusively with the treatment of the sick. It means the entrance of the government in a big way into the practice of medicine.

Of course the Government is in the practice of medicine now and has been for a long time. Some of us are old enough to have watched many of the steps which have taken place. In my own State of Massachusetts, for many years, the insane have been under governmental care. At first, the insane were a charge of the counties. However, there grew up such scandals that all of the county insane hospitals were taken over by the State, after which things improved very much. However, it was a private insane hospital then known as the McLean Asylum and now as the McLean Hospital, a department of the Massachusetts General Hospital, which did the pioneer work in the merciful treatment of those unfortunately mentally ill and out of which developed the idea of positive and humane treatment as opposed to mere custodial care.

I want to emphasize the fact that the original idea in the governmental charge of the insane was purely that of custody and not at all that of treatment. At the present time there are 23,733 beds in the State Institutions for the Insane, and the budget is enormous. To this must be added over 5,000 for the feeble-minded. These institutions are under the care of a Commissioner of Mental Disease. Not so long ago, a capable Commissioner was ousted. His successor was a sick man who, to all intents and purposes, did not function except to draw his salary for a year. Obviously, the political possibilities are limitless. But perhaps even worse are the discouragement of the personnel, the loss of morale, and the difficulties of getting good men to take up this work as a career.

The situation in Public Health in Massachusetts is more interesting and more illuminating. After all, the care of the Insane is a special problem, and so the Medical Profession regards it. Early in the day came governmental water and sewage works. The argument seemed simple. Water and sewage are necessary for the health of all the people and so, with very little opposition, the public or governmental ownership or control of water and sewage became an accepted fact. It all went along nicely, with public roads, public bridges, public ferries and public education. Here and there a private company operated a water supply, a road, or a bridge. In some instances, however, especially in higher education, private institutions challenged the general trend.

At first, the Commonwealth of Massachusetts passed laws in regard to certain diseases declared dangerous to the Public Health. Of course, notable among these was smallpox, and the early pesthouses were operated at public expense. Then, with the advent of vaccination, nothing seemed more reasonable than that the State should supply the vaccine. Then came diphtheria, the free diagnosis of diphtheria and the free supply of diphtheria antitoxin. The argument was that the prevention and cure of diseases dangerous to the public health were measures more for the benefit of the public health than for the patient.

And so in Massachusetts we have nearly 5,000 beds listed for the care of the tuberculous. A few of these are private charities, but mostly they are supported by State, county, and city or town funds. In the instance of tuberculosis, an interesting situation is slowly developing. The federal government, with its Veterans' Hospitals, is also developing institutional care for sick veterans. In the case of the Insane, institutional care lags behind the demand. In the case of tuberculosis, however, the State, in order to keep its beds filled, has altered the policy of admitting only consumptives, the dangerous type of tuberculosis, by devoting some of the institutions to other forms of tuberculosis, as bone, joint, glandular tuberculosis, etc., which are not dangerous to the public health. Indeed, the future brings up the problem of what disposition will be made of some of these tuberculosis hospitals, because the rapidly decreasing incidence of

tuberculosis will not require the existing amount of accommodations.

However, we must stick for the moment to this movement in diseases dangerous to the public health. Nearly every one of those diseases has possibilities of laboratory diagnosis, and many of some specific treatment. Naturally we doctors want the best for our patients, and sometimes the laity wants the newest before the profession has had opportunity of testing the virtues of the latest remedy. The situation in pneumonia illustrates our predicament. Just a short while ago, there were three recognized types of the pneumococcus, and the unrecognizable types were called Type 4. A reasonably effective serum was developed for Types 1 and 2, apparently more effective for Type 1 than for Type 2. This serum had to be administered by vein and often in considerable quantity. The actual cost ran from $30 to $100. Often it was difficult to determine the type. Furthermore, transfer of these sick patients any distance to a hospital often did the patient more harm than the serum did good. Almost overnight we were amazed to find that instead of four types of pneumococci we had over thirty. That necessitated more elaborate laboratory procedures to identify the type and more elaborate work with horses and other animals to develop these other sera. And now again overnight we are furnished with a new chemical, a kind of relative to the chemical known as sulfanilamide which we have just learned how to pronounce and spell and use. And just now no one knows whether all the serum treatment of pneumonia is antiquated or not. Anyway, the profession is all excited about it, and the doctors with their humanitarian impulses are only interested in what is going to help their patients with pneumonia.

There is one more group of diseases which is being taken over by the public health authorities, namely the venereal group, chiefly gonorrhea and syphilis. In the case of syphilis, a strong case is made by the public health officials. The laboratory diagnosis is complicated but accurate. The treatment is long, technical and expensive. In any event, an extraordinary campaign against venereal disease has begun. All the modern technique has been utilized; there has been the preliminary campaign of education, the build-up or the "ballyhoo," etc., etc.

Most of us doctors have gone along, although it is all strange to us. We see every day naked emotions, tragedy, every form of drama, every kind of sorrow and joy. But these grand, dramatic spectacles of human emotion portrayed publicly are foreign to us and run counter to our notions of the privacy of the patient-doctor relationship. However, as I have said, to this point the practicing doctor has gone along with the trend of the times. On occasion he has resented some actions that he felt interfered with his practice. Again, he may have felt unnecessary encroachment of the field of practice. But by and large, this whole movement has been initiated by doctors and has been supported by the doctors. The organized medical profession was the first to preach public health and the first to seek its enactment in law.

Inevitably, however, this movement has spread, and of late has seemed to gather new impetus.

If insanity, feeble-mindedness, tuberculosis, and all the diseases dangerous to the public health are the responsibility of the government, are not all forms of health and disease the responsibility of the government? And so the movement attempts to include chronic diseases, arthritis, cancer, old age, heart disease, etc., as possible public services! And beyond those, any disease! Ought not the federal government, besides having hospitals for veterans, have hospitals for ordinary folk, perhaps beginning with diagnostic centers? There are suggestions that the U. S. Public Health Service start up some diagnostic centers in those large areas where there are said to be no hospitals, or inadequate hospitals. But there is dispute as to the existence of such areas.

Again, one federal department, the Home Loan Owners' Corporation, or something of that sort, donated $40,000 to start a federal health insurance scheme under lay control in the City of Washington, D. C. Whereat there was acrimony, hard words, lawsuits, and other results in the District of Columbia, and the end is not yet. It is hardly a coincidence that suit is being brought against the American Medical Association as a monopoly just at the time the health program is sent to

Congress. Anyway, the doctors have several hundred schemes of their own to counteract this trend. If one attempts to look at the situation dispassionately, it appears that generally speaking the government, federal, State, county, and municipal, has taken over the custodial care of the Insane, and not only the custodial care but various preventive, including diagnostic and therapeutic, measures in that large group of diseases often called the infectious diseases or the diseases dangerous to the public health. Within this preventive category come the governmental responsibility for water and sewage. This leaves the practicing physician the care of the individual sick. Such a division of medical practice has been very rapidly arrived at. And some of us can readily remember when there was little or no division, no state laboratories, no tuberculosis hospitals, no venereal disease programs and few boards of health worthy of the name.

But we hear demands for hospitals for arthritis, hospitals for cancer, hospitals for heart disease, all to be maintained by the government. It has seemed to some of us that certain circumstances which have existed since 1929 have much to do with the present situation and present uncertainty. I refer in part to the economic condition of this country. In the first place, the medical profession has, by its prodigious advances and discoveries, saved lives and increased the duration of life. If there had been no saving of life and no prolongation of life during the last fifty years over the previous fifty years, there would be no unemployment today. In other words, Medicine can and does save lives faster than Industry can find employment for them. But in the years just before 1929 when there was little or no unemployment, one heard little or nothing of the inability of the poor to get adequate medical service. The doctors themselves took all in their stride, rich and poor. And in fact there were hospitals for the poor before there were hospitals for the rich. Somehow or other we doctors staggered through the worst of the depression, and this is more than can be said of some of the other professions and of many businesses. And the doctors are still saving lives and prolonging life. But the load of carrying the whole load of the indigent sick has become increasingly difficult. Our doctors and our hospitals may be considered as entitled to some economic readjustment. But it is not evolution and readjustment, even at the accelerated tempo of the last twenty years, that some want. It is change, complete and entire. Why change when our mortality and morbidity records are indeed remarkable? Change just for change is the reply. Change, that enemy of reason and action, that anaesthetic of the intelligence, as Emerson says. Change because the Economists tell us it is better. But we recall that these Economists assured us for economic reasons the Great War could only last a few weeks or a few months and that not one of these Economists predicted the Depression.

Or perhaps Change because the politicians see possibilities there. Thirty dollars every Thursday kind of change or Fifty dollars every Friday. Obviously, it is better if alliterative. And perhaps there is a venal side. I do not affirm or deny this. I just suggest it.

Education, which has been "socialized," is ordinarily used as an illustration of governmental control of a profession. Indeed, the State Universities and State Medical Schools are used as glowing examples of completely satisfactory governmental activity in Medicine. There are great State Universities and great State Medical Schools. But there are few if any, I think, who would venture to suggest that there should be no privately endowed universities and medical schools, chiefly because the State Universities need the privately endowed Universities. And then, too, Politics raises its ugly head. In Massachusetts recently we saw the discharge of a competent Commissioner of Education. To be sure, Massachusetts does not have a State University (if we except Amherst State College) or a State Medical School. Yet the recent storm of scandal concerning the Teachers' Colleges and possible misuse of funds, all of which have led to the removal of the present Commissioner, gives reason for pause and contemplation.

At the Washington Conference held last summer, a health program was proposed calling for just under a billion dollars a year for the first year or so. Now, I do not know what a billion dollars are, but I think it could be

spent, especially if the government builds many $2,500,000 hospitals for crippled children as it did in New Mexico. They could only collect thirty crippled children from New Mexico, and they did not have an orthopedic surgeon in the state!

Perhaps these teeming millions had nothing to do with the failure of the reappointment of that veteran health officer, Dr. Henry D. Chadwick, in Massachusetts. It is part of the plan to spend much of these moneys through the State Health Departments. Anyway, the present incumbent in Massachusetts may prove to be an excellent man even if untried and supplanting a remarkably fine public official. Dr. Chadwick is the third of three fine public officials in Massachusetts to be fired for the offense of holding a key position. There are no others related to this discussion.

Now, if all the insane, all the feebleminded, all the tuberculous, all those afflicted with infectious diseases or those diseases dangerous to the public health, are looked after by the government, and if we add all the arthritis cases, cancer cases, and then again if all the indigent are cared for by governmental agencies, who are left for the ordinary doctors? And here a new term has been invented, namely, the medically indigent, who embrace twenty to ninety-five per cent of the population. That is to say, if the family, on their budget plan, find themselves skimped by payments on such necessities as the automobile, the radio with the television set, the overstuffed furniture, the fur coat, the trip to the New York World's Fair next summer, and the trip to St. Petersburg, Florida, this winter, such a family is medically indigent if a member gets appendicitis or becomes pregnant. Now it is proposed that for these medically indigent the government build new hospitals, mostly for diagnostic purposes ostensibly, with basal metabolism, sedimentation rates, electrocardiographs, and X-Rays. But we all know that treatment will also come in. Then, of course, the Veterans and perhaps their families will all be treated by the government. And again, there is proposed a compulsory insurance plan for all workers. And now whom does the general practitioner treat, and how is he going to live? The doctor has not any unemployment insurance. He has not any "work and wages" plan. He has not any old age insurance. The others (that is, the political bureaucrats) are all generals, and he is the Mexican Army.

I suppose that expressed in different ways, we were all brought up in the idea that the practice of medicine is the treatment of the sick and the prevention of disease. But now we are told that medicine is a part of economics, of sociology, of social welfare, or of social security. For myself, I confess that a good deal of the argument seems metaphysical. For example, which comes first, the chicken or the egg? Is illness the cause of economic disaster or economic inadequacy the cause of illness? And how can we change the human and personal equation? To me the sight of a splendid funeral means the query of a possible misuse of insurance money. And I am not much heartened by a description of the outlines (only general outlines, mind you, the so-called blue prints) of the national health program as I heard them portrayed by a representative of the Social Security Board in Washington. This representative, not a doctor, described briefly these general outlines of a National Health Program and then went on to say that there had been consultations with various national groups, including the American Medical Association, The Committee of Physicians, The Social Service Workers, The American Osteopathic Association, and American Chiropractic Association, and then he stopped suddenly with a puzzled look, and after a bit of mumbling, went on. I recognized that puzzled look and so would you, I think. It is the look that you spontaneously put on when you receive not one but two sharp kicks on the shin under the table, coming from the direction of your wife, when you are in the midst of one of your best stories, forgetting for the moment that there is not any more ice cream, or that the Jew story is not so good if there are Jews there, or that the jail story will not seem funny to someone just out of jail, etc., etc.

Now, we are all, I think, prepared to admit that the doctors are not all perfect. Our wives would not be everlastingly trying to make us over if we were. And as for the unmarried doctors, there would not be any if they were perfect.

As a trustee of the American Medical Association, I am even prepared to say that the American Medical Association is not perfect and that, while the JOURNAL of the American Medical Association is the best in the world, nevertheless, the editor may not be perfect. And yet perhaps one reason for some clumsiness in handling some of these issues which are political rather than scientific is that the American Medical Association has been busying itself for years with professional and scientific matters.

The Council on Medical Education and Hospitals of the American Medical Association is, I think it is fair to say, largely responsible for putting out of business a large number of inferior medical schools, the most of which were only diploma mills. The Council on Chemistry and Pharmacy has done the most outstanding work in the world in the field of therapeutics. And these are only two activities of a considerable number, which include the publication of several scientific journals. But, as I have said, the doctors are not all perfect, but as a group they have met three great challenges. It is a commonplace that the advances in medicine have been prodigious, and it has been a burden put on every doctor as he begins his practice that somehow, come what may, he must keep pace with these advances.

When I was an interne, there were no Gastro-Intestinal X-Rays, no Wassermann test, no Salvarsan, no basal metabolism, no electrocardiograms, no blood pressure apparatus, etc., and the list is long. I almost added and those were the happy days. But we have kept abreast of the scientific times, just as we learned to drive a motor car and as we shall soon learn to drive an airplane. But that challenge we have met.

Then, too, we have in times of War met the challenge of learning and practicing war medicine and war sanitation. That record is indeed a glorious one.

The Medical Profession has met courageously the challenge of poor medical schools, poorly trained doctors, poor hospitals, and the like, and has of itself corrected those evils so that today the American Medical Profession is the best in the world and its Medical Schools and Hospitals are also superior to those in any other country.

Again, the Medical Profession has met the challenge of the indigent sick, and I doubt if there is an appreciable percentage of doctors who have not contributed their part in the alleviation of suffering in the poor. And in this connection I want to say with all the emphasis at my command that such statements that a considerable fraction, such as a third or anything like it, of our population does not have reasonably adequate medical service on account of an inability to pay for it is silly, inexact and far from the truth. I will agree that some people who need medical attention do not receive it, but the reasons are not largely, if at all, due to the inability to pay but to ignorance, obstinacy, and credulity in quacks, patent medicines, etc. Indeed, the well-to-do are often less sound in their medical belief than the poor.

I give you my own feeble views for what they are worth. We are living in times of change, and the practice of medicine has changed and is changing extraordinarily rapidly. It is probably a fact that in some respects the tempo of these changes is in some instances too slow and again too fast. We will meet these changes as we have met these changes in the past, courageously and, I hope, intelligently.

As I see it, the pressing problems are in the main two. I purposely exclude the normal and rapid development of preventive medicine and public health which will go along with the advances in scientific medicine. I exclude also a troublesome problem, the medical care of the indigent. That is acute and distressing, but it seems to me solvable. I exclude deliberately compulsory health insurance because it inevitably becomes political and therefore costly and inefficient and because it is not suited either to our people or to our doctors and because wherever it has been tried under circumstances much more favorable than would obtain in this country, it has not resulted in (1) better public health, (2) better doctors, or (3) better medical care. The two difficult and pressing problems are (1) continuing education of the doctor to improve the quality of medical service and (2) better distribution of not just medical service but of the best medical service. The solution of these problems will give results in lives and health.

Already the scene buzzes with experimental activities on these two problems. Literally hundreds of schemes of medical service distribution are being tried. It is likely that no one scheme or plan will be suitable north, east, south and west. It is certain, however, that by intelligent trial and error a solution or solutions will be found far more readily than by theoretical and sentimental oratory.

Then, too, our universities, our medical societies of all kinds are earnestly and zealously striving to continue the doctor's education. It is my belief that with the solution of these two problems we do not need any radical change in our social philosophy of medical practice. I do not believe that governmental expenditure on a colossal scale is a sound theory for the solution of any problem. Money is not the universal remedy. The rich get the best medical service just as the poor by the exercise of intelligence and not merely by the use of money. And with vast governmental expenditures come, as inevitably as night follows day, the politicians.

In general, I believe that the governmental activity should be directed toward preventive measures, public health and custodial care of certain special groups of patients. The doctors themselves would continue to care for individual patients, treat the sick and practice, of course, individual preventive medicine. There may be at times conflicts between these two activities, but it seems to me to be intolerable that two great systems of medical practice should operate side by side, the governmental and the private practice of medicine. If such a calamity should occur, the ultimate result is obvious, because the government is a camel and we know what happened when the camel was let partly under the tent of his kindhearted keeper. The doctor, like the kindhearted keeper, would be out in the wet. However, I believe that such a misfortune is by no means inevitable.

I have elsewhere compared the Health Program now before Congress to a Midsummer Night's Dream, a very pleasant dream because everywhere there were streams of gold. And in this dream the streams of gold washed away all the diseases and there were only health and happiness in the land. But there was a rude awakening from this dream when rough voices shouted, "The Tide of gold is in." And those rough voices were those of the politicians.

And over the radio early Sunday morning of this week came this message: "Shortly before 1 a. m. (Eastern Standard Time) the Coast Guard received a message that the Erie had reached the Esso Baytown and was sending a doctor over in a small boat." Just a nameless doctor, even as you or I, not on a panel, not on a shift, not on hours and wages. But in the dark of a Sunday morning, while most of the world slept, he took his bag and went in a small boat on his age-old mission of mercy.

National Institute of Health

Construction will be started immediately on two additional laboratory buildings and living quarters for 14 of the medical officers and their families at the National Institute of Health, near Bethesda, Maryland, Dr. L. R. Thompson, Director of the Institute, announced February 10th.

With the completion of these two new laboratory buildings and the National Cancer Institute Building, which was started last November, Dr. Thompson said that facilities will be available at the Bethesda center for about 600 scientific investigators, laboratory technicians, and research workers. The Institute is concerned with many public health problems, ranging all the way from the control of serums and vaccines to determining the number of hours which bus and truck drivers can work without suffering undue fatigue which endangers life on the highways.

One of the new laboratory buildings will house the Divisions of Infectious Diseases, and Biologics Control. The other will be used by the Divisions of Chemistry, Pharmacology, and Zoölogy. It is expected that the Cancer Institute will be completed early in July of this year, and the laboratories at Cambridge, Massachusetts, and in the Institute buildings at 25th and E Streets, will be moved into the new building at that time.

Treatment of Genito-Urinary Infections with Sulphanilamide

By George A. Schneider, M. D., and Michael J. Harkins, M. D., Lewiston, Maine
Department of Urology, Central Maine General Hospital

1a. Patients should be closely followed and a complete blood count done every two days, while under moderately heavy dosage therapy.

1b. Sulphanilamide is not successful in removing infection where there is obstruction to urinary output as: calculi, etc., or where there is little or no function, as in pyonephrosis. Of course, this drug should be used with extreme care where there is kidney damage showing casts, increased N. P. N. and diminished dye elimination (Psp. test).

2. Toxic symptoms calling for immediate cessation of sulphanilamide are: unexplained fever, jaundice, dermatitis, anemia, agranulocytic angina and blurring of vision (may be seen in heavy smokers). Nausea and dizziness often precede or accompany the anemia, which is of a hemolytic type. In the event of toxic manifestations of the drug, force fluids, per os or parentally, to rid patient of the drug rapidly.

3. The anemia does not respond readily to liver and iron therapy and it is better to transfuse these patients. If the drug is again started on these people who have exhibited an anemia, after they have had a rest period, they very often relapse.

4. Anorexia, nausea, vomiting, dizziness, headache and cyanosis are common complaints while a patient is under sulphanilamide therapy but per se they are not contraindications to sulphanilamide therapy. The cyanosis may be abolished for 8 or 10 hours by intravenous injection of 1 c. c. of methylene blue.

5. Patients exposed to strong sunlight while under moderate or heavy therapy, may exhibit a fine erythematous rash.

6. No drug should be given with the SO_4 radical, and eggs should be eliminated from the diet. No laxatives are given and for bowel stasis, s. s. enemas are used. Some employ mineral oil; sulphanilamide is not oil soluble so that mineral oil does not interfere with therapy.

7. In adults the urinary output should be limited to 1000 c. c. or approximately 1500 c. c. intake, in order to maintain concentration of the drug. Only 50% of the ingested sulphanilamide is active, the rest is excreted, coupled with an acetyl radical which is inactive.

8. The drug should be given for three days, in the event the patient does not show earlier clinical improvement, as it takes about this time to saturate the body.

9. Over a 24-hour period, we give 90 to 100 grains of sulphanilamide to an adult weighing 150 lbs., for three days, then cut the dosage to 60 grains for the next ten days. In acute infections, the drug should not be discontinued after three days' therapy shows amelioration of clinical symptoms, as the infection may again occur and it is more difficult the second time to acquire clinical improvement. Bicarbonate of soda is given with sulphanilamide. We give a 2 to 3 ratio, i. e., 10 grains of bicarbonate of soda with 15 grains of sulphanilamide.

The high dosage therapy for children weighing 10 to 25 pounds is 2 grains per pound for the first 24 hours, then cut to 1 grain per pound, for three days, then three-eights grain per pound.

10. Sulphanilamide may be given by hypodermoclysis; it is soluble in the ratio of 0.8 grams to 100 c. c. of distilled water. The distilled water is brought to a boil and the drug is stirred into it. Give sulphanilamide at 37°C. If cooled it will crystallize out of solution. Solutions should be made up fresh each day. 30 c. c. of ½% or 15 c. c. of 1% sterile Novocain solution, added to 500 c. c. of hypodermoclysis, makes this procedure painless.

11. In toxic patients, where no drugs could be given by mouth, we have obtained good results with Neo Prontosil solution, either 2½% or 5%. It may be given under the skin with Novocain, as used without No-

vocain it causes burning in the subcutaneous area. We have given it by vein in physiological saline, or distilled water, as an emergency procedure. It has high diffusive powers and rapidly appears in the urine. It may be used as an adjuvant to sulphanilamide, in early treatment. It is less toxic than sulphanilamide, although it is thought to be reduced to sulphanilamide in the body. We do not recommend Neo Prontosil by vein except in emergencies, for rapid saturation of the body. Dosage of 2½% Neo Prontosil used has been 1 c. c. per pound in adults, total dosage not to exceed 100 c. c. per 24 hours. For less than 25 pounds of body weight, it may be given in a dosage of 1.5 c. c. per pound. If 5% Neo Prontosil is used, divide this dosage by two.

Gonorrheal Infections Treated with Sulphanilamide

CHILDREN

For children in this hospital, we use the dosage rule of ¾'s grain per pound for the first to third day inclusive, 8/15's grain per pound for the fourth to seventh day inclusive, ⅜'s grain per pound for the seventh to twenty-first day inclusive. This is given with soda bicarbonate in the ratio of two parts to three parts of sulphanilamide. The drug is administered 4 i. d. at six-hour intervals. Children are more prone to the hemolytic anemia than adults.

Adult gonorrhea may be best treated in bed, on high dosage therapy.

Ambulatory Cases of Gonorrhea, Male and Female, Treated with Sulphanilamide

In acute cases the drug seems to function better six to seven days after the active infection starts. We give 15 grains after meals and at bed-time, trying to get four hours between doses, or a total of 60 grains per 24 hours for 16 to 18 days, together with soda bicarbonate in the ratio of 2 to 3. If therapy is to be repeated, a three week's rest between courses of sulphanilamide is advised. In chronic cases, 45 grains daily in divided doses (10 grains p. c. and 15 grains h. s.) is given for 21 days. Gonococcus vaccine twice weekly seems to aid the drug in these cases.

Tobacco in various forms is said by many patients not to taste as well while under sulphanilamide therapy and may cause dizziness if used a great deal. Alcohol acts synergistically with sulphanilamide to cause very severe dizziness, and should be emphatically forbidden while patients are under therapy.

Ambulatory patients receiving sulphanilamide therapy, who are employed around machinery of various kinds such as belts, pulleys, etc., should be closely questioned as regards dizziness. If they experience this symptom it is better that they be treated at home. Patients should also be warned against driving an automobile while under snphanilamide therapy, as some very severe traffic accidents have occurred as a result of this therapy. Ambulatory patients should be seen daily if possible, while undergoing sulphanilamide therapy.

Tucker and Hellwig emphasize the value of routine microscopic examination in proctologic practice. One-third of their malignant lesions were discovered by histologic study of clinically benign lesions of the anal region.—F. E. Kredel, M. D., *The Southern Surgeon,* Dec., 1938.

One candle power of intelligence applied in early diagnosis or in the elimination of the known precancerous situation will be far better than any million volts of irradiation for late cancer displays.—E. H. Skinner, *Radiology,* Oct., 1937.

Two Unusual Foreign Body Cases

By Edward L. Pratt, M. D., F. A. C. S.*, Lewiston, Maine

The first case was a female child two and a half years old. She was admitted to the Central Maine General Hospital with the following history:

The child was playing in a sand pile out in the yard when she suddenly choked and began to cough. When she "became blue in the face," the mother put her finger down the child's throat and the cyanosis cleared up and the coughing ceased. The child seemed all right until about two hours later when she was given some bread and milk which she promptly regurgitated. A little later she was again given some bread and milk and again it was regurgitated. On the advice of the family physician the child was brought to the hospital.

On admission the child seemed to be in no distress. There was no cyanosis, no cough, and no increase in respirations. None of the family could give any clue as to what the child had been playing with. An antero-posterior and lateral X-ray plate was made. The antero-posterior plate showed no evidence of a foreign body in either the food or air passages. The lateral plate, however, showed a foreign body in the esophagus at about the level of the hiatus. It appeared to be about two cm. long and about the thickness of an ordinary paper match. Its long axis did not lie across the esophagus as if it were wedged there, but appeared to be straight up and down in the same plane as the esophagus. This caused us to wonder why a foreign body no thicker than a match should lodge in such a position at the hiatus. The radiographer thought that the shadow was too dense to be a piece of wood and that if it were bone, it ought to show on the antero-posterior view as well as the lateral. He then suggested that it might be a piece of glass, and on cross-examining the mother it was learned that the child was fond of playing with glass.

The child was taken to the operating room and a 7mm. Jackson esophagoscope was passed slowly down the esophagus. The foreign body was visualized at the level of the hiatus, but before a forcep could be inserted the foreign body had disappeared. The esophagoscope was passed slowly down to the cardia but still no foreign body was visualized. The child was immediately taken to the X-ray room but no foreign body was seen, on either antero-posterior or lateral plates, in the esophagus or in the stomach. It was assumed that as the esophagoscope dilated the esophagus in the region of the hiatus that the foreign body slipped into the stomach. Food taken an hour later was not regurgitated. The stools were watched and two days later the foreign body was passed without any discomfort. It proved to be a rectangular piece of glass—like windowpane glass—measuring about 2½ x 2 cm. and about as thick as a paper match. Its four corners were relatively smooth, probably because it had been in the sand for a considerable period. Had all four corners been sharp, it would have presented a very difficult extraction problem.

The case is of interest in showing the value of always having a lateral as well as an antero-posterior X-ray plate, and also in demonstrating that this type of glass does not contain enough lead to show on its flat surface, but can be demonstrated by X-ray if caught "on edge." It is also rather remarkable that so large a foreign body, having passed the crico-pharyngeus constriction, did not also spontaneously pass the hiatal narrowing.

The child suffered no ill effects from the accident and has remained well since then.

The second case was an adult male 52 years old. Before retiring he had his wife spray his nose and throat with a DeVillbiss atomizer fitted with a removable olive-shaped metal tip such as is used for spraying oily solutions.

After spraying his throat his wife noticed that the metal tip was missing. The husband denied having swallowed it, felt no discomfort in his throat, swallowed fluids easily,

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had no sensation of choking nor any cough. Prolonged search of the room failed to find the tip so he came to the Central Maine General Hospital for an X-ray.

When seen at the hospital he had no symptoms of a foreign body in either the food or air passages. Indirect examination of the larynx was unsatisfactory because of gagging. Antero-posterior and lateral X-ray plates were taken. They plainly showed the atomizer tip in the left pyriform fossa.

A Jackson esophageal speculum was passed into the left pyriform fossa and the tip easily removed with a laryngeal alligator forceps. The fact that so large a foreign body as this can be swallowed without the patient's knowledge and without causing any symptoms illustrates how valueless is a negative history. Jackson (1) cites a case of a patient who had exactly the same kind of atomizer tip in the right bronchus one and a half years without knowing that he had inspirated it while spraying his throat.

(1) Jackson, Chevalier, & Jackson, C. L. "Diseases of the Food and Air Passages of Foreign Body Origin," Pg. 138.

"The Cheapest Thing Any Town Can Do With Syphilis Is To Cure It"

That was the keynote of an announcement February 13th, by Dr. R. A. Vonderlehr, Assistant Surgeon General in charge of the Division of Venereal Diseases, United States Public Health Service, of a new nine-point program for syphilis control in the local community.

The program is outlined in a new publication, "Syphilis and Your Town," designed to assist local communities in making an adequate check upon the scope, effectiveness and facilities of local venereal disease control projects. The nine points, set forth in a questionnaire intended to suggest best results from unified action by local groups, are as follows:

1. Do your State and town have a trained public health staff that knows how to deal with syphilis?

2. Does your State require reporting and follow-up on all cases of syphilis?

3. Are patients in your town assured of good syphilis treatment even if they cannot afford to pay?

4. Do physicians and clinics in your town have access to free laboratory service for blood tests?

5. Do your State and town distribute free anti-syphilitic drugs to all physicians and clinics?

6. Is every expectant mother required to have a blood test in your State?

7. Are medical certificates, including a blood test for syphilis, required before marriage in your State?

8. Does every complete physical examination given in your town include the blood test?

9. Has your town an education program aimed at age groups most frequently acquiring syphilis?

Dr. Vonderlehr pointed out that public education is the crux of syphilis control, and added, "People must learn to consult a doctor or clinic. They must know that drugstore remedies and self-treatment are worthless. They must know that treatment begun early will cure syphilis in nearly every case, while, if left untreated, the patient is likely to develop brain, heart, or nervous system complications."

"Syphilis control programs," said the new publication, "should make provision for blood tests, not only for prenatal examination but as routine for every hospital patient and a part of every insurance examination. Life expectancy of untreated syphilitics is 20 per cent lower than normal."

Dr. Vonderlehr concluded by insisting that the public must realize the cost of syphilis —its share in lives wasted, its toll in dollars. "All this is preventable if adequate control programs can be started and continued in every part of the country," he declared. "It will be cheaper, too—the cheapest thing any town can do with syphilis is to cure it."

Case Reports from Staff Meeting Held at the Thayer Hospital, January 26, 1939

Dr. T. E. Hardy, *Abstract Editor*

Dr. E. H. Risley: "A physician 57 years of age, with a negative past history, was taken with acute abdominal pain, nausea, vomiting, and fever following an 18-hour period of abdominal discomfort. Onset was complicated by a severe respiratory infection. There was complete lack of localizing signs, but there was a question of some resistance in the left lower quadrant. White blood count was 8,000, polys. 62%. X-Ray of chest was negative. Flat plate of abdomen showed marked dilatation of jejunum. Coughing persisted in paroxysms. Distention became more marked, and signs gradually became localized to right lower quadrant. White blood count went subsequently to 18,000 and to 23,000 with 95% polys. Operation, under spinal anesthesia, revealed purulent fluid in the peritoneal cavity, appendix at midline, ruptured at 1½ inch from base and containing two fecoliths. Abdomen was drained. Convalescence has been uneventful."

Dr. A. H. McQuillan: "I saw this case in consultation. The disturbing feature to all of us was the delay in diagnosis, due to the early lack of localizing signs, the severe acuteness of pain and the low white blood count. This was not an infectious process. I feel that a paroxysm of coughing may have started the fecolith, causing obstructive necrosis with subsequent perforation."

Dr. E. H. Risley: "I cannot quite agree, as I feel the peritonitis was of at least 24 hours' duration, that perforation occurred earlier."

Dr. F. T. Hill: "Does not the early low white blood count denote obstruction rather than infection?"

Dr. E. H. Risley: "There was unfortunate delay due to the question of pneumonia."

Dr. A. H. McQuillan: "There was a trace of bile and sugar in the urine. We had to consider pancreatitis."

Dr. E. R. Irgens: "Parotitis may be epidemic, metastatic from infection, due to infection extending up to Stenson's duct, or the so-called sympathetic type following abdominal operations. Another type is reported—a 25-year-old woman, due to direct extension from acute otitis media. The cartilagenous portion of the external auditory canal has a cleft known as the Fissure of Santorini. The retro-mandibular portion of the gland bends around the condyle so that it really lies between the canal and the condyle. In this case the discharge from the middle ear caused infection in the parotid by extension through the Fissure of Santorini."

Dr. R. L. Reynolds: "Would it be good surgery to drain these cases externally? I have seen cases where the facial nerve has been injured by so doing."

Dr. F. T. Hill: "Drainage should be carried out externally if the process does not subside or cannot be drained through the Stenson's duct. There should be no danger of injury to the facial nerve if the procedure is properly done and the gland incised in a horizontal direction. Post-operative fistula can easily be taken care of."

In all curable and borderline cases wherein the emotional stability is good, patients should be told their true condition because it helps them to realize more fully the importance of treatment and will insure a closer conformity to the rules and instructions of treatment and will increase the coöperation necessary for successful follow-up.—Dr. E. E. Downs, Dr. Hoke Wammock, and Dr. R. T. Artman, *National Bulletin of the American Society for the Control of Cancer,* Jan., 1939.

Meeting of the New England Oto-Laryngological Society, April 13, 1938, at the Massachusetts Eye and Ear Infirmary, Boston, Mass.

Dr. William Goodell, President; Dr. Werner Mueller, Abstract Editor

Report of Several Interesting Bronchoscopies. Dr. Chester R. Mills, Boston.

Case 1: A 16-year-old girl gave a history of having inhaled one or more common pins. An antero-posterior X-ray showed one pin in the hypopharynx, another apparently in the chest at the level of the second and third ribs. The first one was readily removed, the other could not be found either in the lung or in the esophagus. Study with the bi-plane fluoroscope finally revealed that what was at first thought to be the pin in the chest turned out to be a broken hypodermic needle in the soft tissues of the shoulder. Past history showed that the patient had several years previously been given a hypodermic injection which had caused her to jump.

Case 2: Male, 54 years old. This patient's chief complaint was dyspnœa on exertion and after eating, frequent gastrointestinal upsets, eructations of gas, increasing constipation and precordial pressure. These signs had been increasing during the past five years. There was no loss of weight. Physical signs in the chest were consistent with compression of the lungs, especially on the right side. A preliminary diagnosis of extra-bronchial new growth was made. X-rays showed a mass in the right chest with the heart pushed to the left. Bronchoscopy was done under local anesthesia. There was complete blocking of the right main bronchus due to extra-bronchial compression. Lipiodol injection showed several lobulated areas of air in the right pleural cavity. A barium meal and enema was given which showed a large diaphragmatic hernia on the right side with the cecum and ascending colon in the right pleural cavity.

Case 3: A boy 10 years of age was referred from the Medical Service for persistent cough, failure to gain weight, dyspnœa and precordial pain. He gave a history of having been struck by a truck when he was five years old. He had several fractured ribs and a collapsed lung at that time. He spat up some blood and was in the hospital 10 days. Since then he has been in the wards of the Boston City Hospital in 1934, 1936, and 1937, because of one or more of the above symptoms. Physical examination has always shown atelectasis of the left lower lobe. He had always been negative for tuberculosis. Two gastrointestinal series ruled out diaphragmatic hernia although the signs were very suspicious. His last admission to the hospital was in December, 1937. Bronchoscopy showed the left main bronchus completely obstructed with displacement of the trachea to the left. Lipiodol was instilled through the Stitt catheter. The catheter passed into the left main bronchus but the lipiodol failed to flow into the atelectatic lung. The right lung was readily outlined. The Thoracic Service is now studying the case and the question of lobectomy is being considered.

Relationship of Pituitary Dysfunction to Frontal Osteomyelitis and Petrositis. Drs. Leighton F. Johnson and George Levene, Boston. Report Read by Dr. Johnson.

Following the work of Drs. Mortimer, Levene, and Rowe at the Evans Memorial on the typing of crania from the standpoint of pituitary dysfunction, the authors studied the incidence of osteomyelitis of the skull and petrositis through the medium of endocrinology.

They found that cranial osteomyelitis of sinus origin and petrositis usually occur only in skulls showing anterior pituitary lobe overactivity. Such skulls are characterized by spongy, rarefied, vascular bone and hyperpneumatization of the sinuses, mastoids and petrous pyramids.

Atelectasis of the Newborn. Dr. George O. Cummings, Portland, Maine.

The author's case was that of a newborn infant showing respiratory difficulty at the time of delivery by cæsarian section. The baby had never cried vigorously and at birth a considerable amount of fluid had been drained from its pharynx by posture and aspiration. It had been given respiratory stimulants and subcutaneous saline and had at times been placed into an infant-size Drinker respirator. A chest X-ray showed atelectasis of the right upper lobe. This was in this case obviously not due to obstetric difficulties nor had the mother been given an excessive amount of pre-operative medication.

After having duly considered the usual causes of atelectasis and the fact that even massive post-operative collapse almost invariably clears in time with the shifting of the patient's position, it seemed best to let the child alone. Direct laryngoscopy with aspiration was not done because of the shock it might cause. Seventeen hours after delivery the baby died of a sudden respiratory failure that suggested the sudden release of a mucus plug with a complete blocking of the trachea.

After having discussed the various old and new methods of resuscitation, the author suggested that the bronchoscopists of the various hospital staffs should instruct residents or attending obstetricians in the use of the laryngoscope in the newborn.

Use of Physical Therapy in Otolaryngology. Dr. John L. Myers, Kansas City, Mo. By Invitation.

This paper has appeared in full in the 1937 Transactions of the American Academy of Ophthalmology and Otolaryngology. In it the author discusses the physical and therapeutical properties of the Spectrum of Radiation as well as the agents for the production of the various regions of this spectrum, from the humble hot water bottle to the most complex electrical apparatus. Tumors are classified as to their response to radiation. The electrocoagulation of tonsils is put in its proper place. Sun worshippers are told that sunlight is only one of many vitalizing factors necessary to prevent disease and to maintain health. For those who wish to go into this subject more deeply, a bibliography of 26 titles is added. The author's conclusions are as follows:

1. Progress is being made in the therapeutic use of radium and the Roentgen-ray.
2. The action of light, ultra-violet, infra-red, and luminous rays, has not been scientifically established, though evidence enough has been given to show that through further research it may prove to be a potent therapeutic agent.
3. The medical and surgical use of heat produced by the infra-red rays and the Hertzian waves is of value in combating disease.
4. Much more research is necessary before the full therapeutic value of energy in the spectrum is known.
5. There must be closer coöperation between and group work among physicians in order to secure optimum therapeutic results.
6. We must "try all things, prove all things, hold fast to that which is good."

Schiller distinguishes carcinoma of the cervix from normal epithelium by three characteristics: First, the diseased area is elevated; second, the surface is not smooth and shiny but somewhat dull; and third, the carcinomatous epithelium is somewhat opaque. —Walter Schiller, Pathology of the Cervix, *Am. Jour. of Obs. & Gynec.*, XXXIV: 430-438, Sept., 1937.

If an exact diagnosis is made as soon as the patient notices unusual or irregular bleeding or an unusual or abnormal discharge, enough cancers can be discovered at an early stage so that the number of cures can be doubled.—Arthur W. Erskine, M. D., in *The American Journal of Roentgenology and Radium Therapy,* Dec., 1938.

The President's Page

To the Members of the Maine Medical Association:

As I write this President's Page for the month of March, I cannot help but wonder if the members of the Maine Medical Association fully realize the amount of work that has been done by our Legislative Committee and our Attorney, Mr. Locke, during the term of Legislature in the past month. Many undesirable bills have confronted us as well as questions to be decided relative to Medical Legislation, all of which have necessitated many miles of travel over icy roads and midnight lunches in diners. In fact, owing to our present dilemma, the Maine Central Railway is at last on the road to financial recovery.

Furthermore, during the month of February it might be well for our members to know that we have been obliged to call two full meetings of the Legislative Committee, the first at Augusta, and the second at Hallowell.

It also was necessary that we have a meeting of the Advisory Committee at Portland, which was fully attended. This, however, was a pleasure because at that time we availed ourselves of the pleasant hospitality offered to us by our Chairman, Carl M. Robinson, M. D. This meeting was held at his colonial home at Falmouth Foreside, where a bountiful dinner was served followed by a pleasant evening spent around his large fireplace in his spacious living room. In fact, this was voted by all present as one of the bright spots of the year.

Quoting our efficient Secretary Dr. Carter, "Everything is going to be lovely." To this we heartily agree. But if so it is because of the fact that the members of our Legislative Committee have freely offered their time and money in order that they might honestly fulfill their duties as members of this Committee. Mr. Herbert Locke, our Attorney, and Dr. Frederick R. Carter, our Secretary, in their quiet and dignified manner have handled the situations as they arise in a way that would be complimentary to the officers of any organization.

And in closing, I would ask each individual member during his hours of deepest thought to carefully analyze the situation as it is at the present day, and in the near future be prepared to lend their support to these difficult problems that cannot possibly be decided by any one committee of our Association.

Willard H. Bunker, M. D.,
President Maine Medical Association.

Editorial

The Place of the Panel Discussion in a Program of Graduate Education

In the past two years we have witnessed the general acceptance of the idea that Organized Medicine must assume the responsibility for a continuation program of education, for the Profession. Hithertofore any effort along this line was largely left to the initiative of the individual physician. To be sure the National and Sectional Medical Societies have carried on scientific programs of real merit for years, but these have resulted in but little progress in the education of the great mass of physicians, except insofar as the publication of the proceedings reached and was assimulated by these men. State and County Associations tended to a degree toward scientific standards, but at best it was a sketchy and haphazard program which was presented.

At last Medicine awakened to the fact that it had a definite responsibility. We assume to care for the physical ills of the people. Therefore we must see to it that people are adequately taken care of, that they have the best and most scientific medical attention. This means our practitioners must be abreast of the times and thoroughly cognizant of every advance that the Profession has made. Unfortunately in the past it has been assumed that the responsibility for medical education rested largely with the medical school. We now must realize that this responsibility of the medical school ceases at the time of graduation, and yet a physician's education must be continued, must go on from year to year, for Medicine is not static. Therefore where the initiative of the individual is lacking, Organized Medicine itself must assume this responsibility in order to provide the necessary modern scientific medical care which is so necessary for the well-being of the public.

In the past few years, various programs have been tried in different states. Some have been most ambitious, some have been rather meager, some have been successful, some have been only fairly so. Conditions vary in different states. The program most efficient for one might not fit conditions in another state. In our state, for example, we cannot hope to duplicate the extensive and ambitions program of Michigan.

Here in Maine, for several years, we have been gradually and consistently improving the programs of our state meetings, bringing them up to a better educational standard. That this has been worthwhile is evident by the increased interest and attendance on the part of our members. We have constantly endeavored to improve the character of the County Association's programs and feel that considerable progress has been made. We have been peculiarly fortunate in respect to the fellowships available under the Commonwealth and Bingham Funds, which have enabled many of our practitioners to take much-needed post-graduate courses at no great personal sacrifice. But all these have not taken care of the great mass of our profession. Those who have attended our State meetings consistently have benefited. Those who have had the initiative to apply for post-graduate courses, and have been fortunate enough to have been able to have obtained these, have gained thereby. But still there seems to be the necessity of carrying this idea of Continuation Education further throughout the confines of our state. Just how to best accomplish this has been a problem which the committee on Graduate Education has assiduously studied. We have considered the idea of extension programs to be carried into the various Councilor districts and this may prove to be a valuable adjunct to our program.

This past year we have endeavored to develop the panel system of program. This is a very popular and efficient type of program, of somewhat recent development, but one which has proven a most useful means for disseminating knowledge. The panel discussion is now found on the programs of practically all of the National Scientific Societies.

Much more can be accomplished through this type of program than through any single or multiple set of papers. To those unfamiliar with the panel discussion perhaps a few words of explanation may not be amiss. Usually six or more men are assigned to a panel, each taking up some certain phase of the subject under discussion. Each man is usually confined to ten to fifteen minutes for his presentation. During his presentation any of the other men on the panel may interject objections, questions, or any point that they wish to discuss. This makes it a lively continuous debate, rather than any series of set papers. Questions from the floor are sent up on paper and assigned by the Chairman of the panel to whatever member he feels most qualified to answer it. Should his answers not appeal to other members of the panel they immediately enter their objections. In such a manner any topic can be thoroughly covered in approximately two hours and done in such manner as not to tire the audience, or allow them to lose interest; something that could not happen were any one man presenting a paper.

Already two panels have been prepared, on the subjects of "Pneumonia" and "Cardiovascular Disease." The former has been presented at one county meeting where it met with a great deal of interest. It is already on the program for a number of other counties. Two or three other panels on different subjects are now in preparation and will be available in the near future. It is felt that these offer some of the best opportunities for graduate education possible in Maine. County secretaries desirous of availing themselves of one or more of these panels are asked to write to the Committee on Graduate Education as early as possible, so that dates may be arranged.

Frederick T. Hill, M. D.,
Chairman Committee on Graduate Education.

With the Women's Field Army

News from the Front

Plans for the 1939 campaign of the Womens Field Army are being completed under the direction of the Volunteer Campaign Committee consisting of Samuel Stewart, Lewiston, Chairman; Mrs. John H. Huddilston, Orono; Mrs. William Holt, Portland; Frederick T. Hill, M. D., Waterville; with Edward H. Risley, M. D., a member ex-officio.

April has been designated as Cancer Control Month by the American Society. The intensive campaign will be carried on in most communities in Maine during the week of April third, although the entire month will be given over to the work, for the benefit of those groups who cannot carry on a campaign during the first week.

Continuing the fine coöperation of the medical profession with the Women's Field Army, the following physicians have accepted appointment as chairmen of the Advisory Boards in the districts throughout the State:

ANDROSCOGGIN COUNTY: George H. Rand, M. D., Livermore Falls; W. E. Viles, M. D., Turner; Lester P. Gerrish, M. D., Lisbon Falls; John J. Busch, M. D., Mechanic Falls; George B. O'Connell, M. D., Lewiston-Auburn.

AROOSTOOK COUNTY: Arthur T. Whitney, M. D., Houlton; Storer W. Boone, M. D., Presque Isle; Herrick C. Kimball, M. D., Fort Fairfield; Oscar Norrell, M. D., Caribou; Joseph L. Albert, M. D., Fort Kent; Clyde I. Swett, M. D., Island Falls; and Albert H. Damon, M. D., Limestone.

CUMBERLAND COUNTY: John M. Bischoffberger, M. D., Raymond-Bridgton; Henry W. Beck, M. D., Gray; Howard Hamblen, M. D., Windham; Robert C. Pletts, M. D., Brunswick; Louis L. Hills, M. D., Westbrook; Ervin A. Center, M. D., Sebago-Steep Falls; Robert B. Love, M. D., Gorham; Howard Sapiro, M. D., Scarboro; Nessib S. Kupelian, M. D., New Gloucester; Nat B. T. Barker, M. D., Yarmouth; Harvey Howard, M. D., Freeport; John E. Gray, M. D., Cumberland; and Langdon T. Thaxter, M. D., Portland.

FRANKLIN COUNTY: George L. Pratt, M. D., Farmington; Raymond B. Colley, M. D., Wilton; John H. Moulton, M. D., Rangeley; and Clarence Dunlap, M. D., Kingfield.

HANCOCK COUNTY: Raymond V. N. Bliss, M. D., Blue Hill; John G. Chadwick, M. D., Bucksport-Tremont; Ralph W. Wakefield, M. D., Bar Harbor; George Parcher, M. D., Ellsworth; Charles Sumner, M. D., Hancock; B. Lake Noyes. M. D., Stonington; and Harold S. Babcock, M. D., Castine.

KENNEBEC COUNTY: Frank B. Bull, M. D., Gardiner-Hallowell; Greenleaf H. Lambert, M. D., Winthrop; Arthur A. Shaw, M. D., Clinton; Arnold W. Moore, M. D., Mt. Vernon; Walter W. Hendee, M. D., Vassalboro; Ralph L. Reynolds, M. D., Waterville; and Vincent T. Lathbury, M. D., Augusta.

KNOX COUNTY: William A. Ellingwood, M. D., Rockland; C. Harold Jameson, M. D., Camden; and Victor H. Shields, M. D., Vinalhaven.

LINCOLN COUNTY: Stanley R. Lenfest, M. D., Waldoboro; Robert W. Belknap, M. D., Damariscotta; DeForrest S. Day, M. D., Wiscasset; George A. Gregory, M. D., Boothbay Harbor; and Abbott J. Fuller, M. D., Pemaquid.

OXFORD COUNTY: William M. Monkhouse, M. D., Fryeburg-Lovell; Roswell E. Hubbard, M. D., Waterford; Delbert M. Stewart, M. D., Norway-South Paris; Eugene M. McCarthy, M. D., Rumford; Horace J. Binford, M. D., Mexico; Charles W. Eastman, M. D., Canton; and Garfield G. Defoe, M. D., Dixfield.

PENOBSCOT COUNTY: Forrest B. Ames, M. D., Bangor; Martin C. Madden, M. D., Old Town; Asa C. Adams, M. D., Orono-Veazie; Wesley C. MacNamara, M. D., Lincoln; Henry E. Whalen, M. D., Dexter; LeRoy H. Smith, M. D., Hampden-Orrington; Ernest T. Young, M. D., Millinocket; and George N. Higgins, M. D., Newport.

PISCATAQUIS COUNTY: Albert M. Carde, M. D., Milo; E. D. Merrill, M. D., Dover-Foxcroft; Norman H. Nickerson, M. D., Greenville-Monson; Ralph H. Marsh, M. D., Guilford; and R. C. Stuart, M. D., Sangerville.

SAGADAHOC COUNTY: A. A. Stott, M. D., Bath.

SOMERSET COUNTY: Harry W. Smith, M. D., Norridgewock; Maurice E. Lord, M. D., Skowhegan; Merlon A. Webber, M. D., Pittsfield; Franklin Ball, M. D., Bingham; Percy E. Gilbert, M. D., Madison; and Henry E. Marston, M. D., North Anson.

WALDO COUNTY: Carl H. Stevens, M. D., Belfast; and LeRoy H. Smith, M. D., Winterport.

WASHINGTON COUNTY: William A. Van Wart, M. D., Cherryfield; Clarence W. Milliken, M. D., Jonesport; Oscar F. Larson, M. D., Machias; John L. Murphy, M. D., Eastport; Willard H. Bunker, M. D., Calais; John T. Metcalf, M. D., Lubec; Alton K. Curtis, M. D., Danforth; David Hunter, M. D., Vanceboro; and James W. Crane, M. D., Woodland.

YORK COUNTY: Paul S. Hill, Jr., M. D., Biddeford-Saco; James H. MacDonald, M. D., Kennebunk; Gerald Smith, M. D., Ogunquit; William T. Elliott, M. D., North Berwick-South Berwick; Charles W. Kinghorn, M. D., Kittery; Stephen A. Cobb, M. D., Sanford-Springvale; Paul C. Marston, M. D., Cornish; and Arthur G. Wiley, M. D., Buxton.

Figures compiled at headquarters show the scope of the service given through the Dr. Joseph W. Scannell Memorial Fund. Every county is represented by patients treated from May to October, 1938, when the fund became exhausted. Of the 194 needy cases treated, 86 were men and 108 were women, with the following county distribution: Androscoggin, 28; Aroostook, 18; Cumberland, 35; Franklin, 1; Hancock, 14; Kennebec, 12; Knox, 6; Lincoln, 1; Oxford, 6; Penobscot, 18; Piscataquis, 5; Sagadahoc, 5; Somerset, 9; Waldo, 15; Washington, 8; and York, 13.

As the 1939 campaign starts, the Women's Field Army expresses again its appreciation for the coöperation of the Maine Medical Association in its two years of existence and looks forward to the same interest and help in this campaign and in the work of the coming year.

Ten Golden Rules of the Cancer Examination

1. Examine the lips, tongue, cheeks, tonsils, and pharynx for persistent ulcerations, the larynx for hoarseness and the lungs for persistent cough.

2. Examine the skin of the face, body, and extremities for scaly, bleeding warts, black moles, and unhealed scars.

3. Examine *every* woman's breast for lumps or bleeding nipples.

4. Examine the subcutaneous tissues for lumps on the arms, legs, or body.

5. Investigate any symptoms of persistent indigestion or difficulty in swallowing. Palpate the abdomen.

6. Examine the lymphode system for enlargement of the nodes of the neck, axilla, or groin.

7. Examine the uterus for enlargement, lacerations, bleeding, or new growth. Make a bimanual examination to determine the condition of the ovaries.

8. Examine the rectum and determine the cause of any bleeding or pain.

9. Examine the urine microscopically for blood.

10. Examine the bones and roentgenograph any bone which is the seat of a boring pain, worse at night. — Frank E. Adair, M. D., in *Southern Medicine & Surgery*, Aug., 1937.

County News and Notes

County Secretaries—Attention!

The Committee on Graduate Education has prepared panel discussions which are now available for County Medical Society meetings. It is hoped that you will all make use of these programs. To do so please write directly to the Chairman.

Pneumonia—F. T. Hill, M. D., Waterville, Chairman.

Cardio-Vascular Disease—E. E. Holt, Jr., M. D., 723 Congress Street, Portland, Chairman.

Laboratory Procedures and Their Relation to Clinical Medicine—Julius Gottlieb, M. D., Lewiston, Chairman.

The Acute Surgical Abdomen—Frank H. Jackson, M. D., Houlton, Chairman.

Fractures—Allan Woodcock, M. D., Bangor, Chairman.

Androscoggin

The regular meeting of the Androscoggin County Medical Society was held February 16, 1939, at the Auburn Y. M. C. A., at 8.15 P. M.

Minutes of the last meeting were read and approved.

A report of the T. B. Association was given by Dr. Russell and was placed on file. An expression of appreciation to the members of the Society active in this work was made and that the Medical Society should continue.

The Committee investigating the telephone rates reported and a discussion followed.

Following the business meeting very interesting papers on Caesarean Section were presented by Dr. Linwood Sweatt and Dr. L. C. Gross. A lively discussion followed.

Meeting adjourned at 11.00 P. M.

Respectfully submitted,
W. P. Webber, *Secretary.*

Cumberland

Roger I. Lee, M. D., spoke on "The Doctor's Dilemma, when and if the Government goes into the Practice of Medicine in a Big Way" (this paper appears elsewhere in this issue) at the Cumberland County Medical Society meeting held January 27, 1939, at the Eastland Hotel.

The meeting was preceded by a clinic at the Maine General Hospital at 4.30 P. M., at which the following program was presented:

Embryonic Carcinoma of Testicle—R. L. Huntress, M. D.

Sloughing of Legs—G. A. Tibbetts, M. D.

Vaginal Hysterotomy—P. H. McCrum, M. D.

Acute Pancreatitis—T. C. Bramhall, M. D.

Two Cases of Severe Headache—J. R. Hamel, M. D.

Chronic Supperative Otitis Media with Intracranial Involvement—C. H. Gordon, M. D. and H. E. MacDonald, M. D.

Harold V. Bickmore, M. D., *Secretary.*

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, January 3rd, at 8.15 P. M. Twenty-seven members and one guest were present.

Dr. Albert D. Foster and Dr. Jack Spencer were elected to membership.

Dr. Edward A. Greco gave an interesting paper on The Heart in Lung Diseases. The value of the talk was increased by the lantern slides and x-rays used to demonstrate important points.

Alice Whittier, *Secretary.*

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, February 7th, at 8.15 P. M. The meeting was well attended, forty-three members and two guests being present.

A symposium on *The Diagnosis and Treatment of Joint Disease* was conducted with the following members participating:

Dr. T. A. Martin dealing with the shoulder joint.

Dr. W. L. Casey dealing with the sacro-iliac joint.

Dr. C. C. Corson dealing with the knee joint.

Dr. H. W. Lamb dealing with the ankle joint.

Dr. E. S. Hall dealing with the hip joint.

Alice Whittier, *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at the Elmwood Hotel in Waterville, Maine, Thursday, February 16, 1939, to which the members of the Franklin, Somerset and Waldo County Medical Associations were invited.

Clinical Session was held at 5.00 P. M., which was presided over by Leon D. Herring, M. D., President.

(1) Old Ruptured Gall-Bladder Found at Operation—A. H. McQuillan, M. D.

(2) A Case of Cholelithiasis—Harvey Bourassa, M. D.

(3) Ruptured Gall-Bladder and Incarcerated Inguinal Hernia—E. H. Risley, M. D.

(4) Panophthalmitis As a Complication of Pneumonia—V. C. Totman, M. D.

(5) Olecranon Bursitis—E. M. Tower, M. D.

(6) Carcinoma of Larynx, Laryngectomy, Artificial Larynx—F. T. Hill, M. D.

(7) Cæsarean Section—W. H. Walters, M. D.

(8) Plastic Operation for Deformity of Face Secondary to Operation for Carcinoma of Antrum—E. R. Irgens, M. D.

(9) Laceration of Orbit—L. A. Guite, M. D.

(10) Osteochondroma of the Frontal Sinus—T. C. McCoy, M. D.

Dinner at 6.30 P. M. followed by a business meeting. The minutes of the last meeting were read and approved.

Resolutions on the recent death of Ralph D. Simons, M. D., of Gardiner, were read by A. B. Libby, M. D. Resolved that a copy of the resolutions be spread upon the records of the Kennebec County Medical Association, and that a copy be sent to the bereaved family.

Scientific Session: 7.30 P. M.

Panel Discussion—Pneumonia.

Chairman, Frederick T. Hill, M. D., Waterville.

History and Examination—Theodore E. Hardy, M. D. Waterville.

Pathology and Laboratory Studies—Julius Gottlieb, M. D., Lewiston.

X-ray—Langdon Thaxter, M. D., Portland.

Cardiac Complications—Eugene Drake, M. D., Portland.

Surgical Complications—Stephen A. Cobb, M. D., Sanford.

Medical Treatment—E. R. Blaisdell, M. D., Portland.

This discussion was under the auspices of the Committee on Graduate Education and was ably presented and brought out much valuable discussion.

There were 55 members and guests present.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary-Treasurer.

Knox

The scheduled meeting of the Knox County Medical Association was held at the Copper Kettle, Rockland, Maine, February 14th. The meeting was called to order by Dr. Howard Apollonio, President. The minutes of the last meeting were read and approved. A letter from Dr. Carter, Secretary of the State Association, in regard to reports asked for in the National Survey read. This program was discussed by Dr. Jameson and Dr. Ellingwood, who pleaded for completion of these records and stressed their importance.

A letter from Dr. Carter concerning panel discussions by the Committee on Graduate Education was read. Dr. Torrey of Searsport extended an invitation to Belfast on March 23 to a joint meeting of three societies with the panel discussion on Fractures.

A letter from the Red Cross thanked the Medical Society for assistance at a recent Diphtheria Toxoid Clinic at which 1,185 children were given immunizing doses. The report shows what a great amount of work was done, and 80% of the total school enrollment is a large percentage.

Dr. Coombs of Augusta expressed the desire of the Health Department that a Schick test be made in six months in connection with the program for immunization. He also stressed the importance of examination for Scurvy, and explained the reason why French-Canadian families do not have it so frequently.

After a flowery introduction, Dr. Everett D. Kiefer gave a very clear and concise talk, really worthwhile, on *The Management of Ulcerative Colitis and Functional Colonic Disorders.*

This was discussed by Dr. Clapp of Lewiston. Drs. Laughlin, Soule, Curtis, Hutchins, Apollonio, Greene and Jameson, all asked pertinent questions, which were answered by Dr. Kiefer. Much interest and a very considerable knowledge of the subject was shown.

The meeting was adjourned.

A. J. FULLER, *Secretary.*

Oxford

A combined meeting of the Oxford County Medical Society and the Bingham Associates was held Monday, January 23, 1939, at Rumford, Maine.

Program

At Rumford Community Hospital

4.00 P. M. Clinic. Case discussed by Dr. S. J. Thannhauser, Boston, Massachusetts.

5.30 P. M. Business meeting of the Oxford County Medical Society.

At Hotel Harris

6.30 P. M. Dinner.

7.30 P. M. Lecture, Diseases of the Liver, by Dr. S. J. Thannhauser.

There were twenty-four members and guests present.

J. S. STURTEVANT, M. D., *Secretary.*

Penobscot

The regular meeting of the Penobscot County Medical Association was held Tuesday, February 21st, at 7.00 P. M., at the Bangor House.

The speaker of the evening was S. J. Thannhauser, M. D., Assistant Director of the Joseph H. Pratt Diagnostic Hospital, at Boston, Massachusetts. Dr. Thannhauser spoke on the subject: *Liver Diseases.*

Joseph Memmelaar, M. D., of Brewer, Norman W. Loud, M. D., of Bangor, and Herbert L. Taylor, M. D., of Dexter, were elected to membership.

FORREST B. AMES, M. D., *Secretary.*

New Members

Penobscot

Norman Wiley Loud, M. D., Bangor.
Joseph Memmelaar, M. D., Brewer.
Herbert Lewis Taylor, M. D., Dexter.

Have You Paid Your 1939 State and County Dues?

To insure being in the annual roster, which is to be printed in the May issue of the JOURNAL, members must be reported in good standing by their County Secretary on or before April 1st.

Coming Meetings

County Medical Societies

Kennebec

Kennebec County Medical Association, Frederick R. Carter, Augusta, Secretary.

March 16, 1939, at the Augusta General Hospital.

April 20, 1939, at the Gardiner General Hospital. Speaker: Samuel Levine, M. D., Boston. Subject: *The Ausculation of the Heart.*

May 18, 1939, at the Veterans' Administration at Togus, Maine.

Knox

Knox County Medical Association, A. J. Fuller, M. D., Pemaquid, Secretary.

The next meeting of the Knox County Medical Association will be held April 11th. Subject and speaker to be announced later.

American Medical Association

American Medical Association, St. Louis, May 15-19, 1939

State Medical Associations

Connecticut State Medical Society, New Haven, May 25-26. Creighton Barker, 258 Church Street, New Haven, Connecticut, Secretary.

Maine Medical Association, Poland Springs, June 25-26-27. Frederick R. Carter, 22 Arsenal Street, Portland, Maine, Secretary.

New Hampshire Medical Society, Manchester, June 8-9. C. R. Metcalf, 5 S. State Street, Concord, New Hampshire, Secretary.

Massachusetts Medical Society, Worcester, June 6-7-8. Alexander S. Begg, 8 Fenway, Boston, Massachusetts, Secretary.

Rhode Island Medical Society, Providence, June 7-8. Guy W. Wells, 124 Waterman Street, Providence, Rhode Island, Secretary.

Vermont State Medical Society, Burlington, 1939. Benjamin F. Cook, 46 Nichols Street, Rutland, Vermont, Secretary.

Necrology

Frederick Augustus Bragdon, M. D., 1858-1939

Doctor Frederick Augustus Bragdon, last of the community's family doctors of the old school, died at his home, at Springvale, January 24, after an illness of three months.

A practicing physician for more than 55 years, Dr. Bragdon was the son of the late George and Amanda Bragdon, born at Limington, October 24, 1858. He received his early education in the schools of that town and at the age of 19 accepted a position as teacher in the public schools at Cornish, retaining the post for five years. It was while he was teaching in Cornish that he took his first steps in the field of medicine, studying with Dr. John T. Wedgewood in the periods he was able to spare from his school duties. Later he completed the medical course of the Maine Medical School of Bowdoin College, graduating with honors in 1883. The following year he started practicing in Shapleigh, where he met and married Miss Nellie Welch, then the district school teacher, November 24, 1884.

In 1886 and 1891, he completed post graduate medical courses in New York, being anxious to keep abreast of the newest developments in his chosen field. Then having conducted a practice in Shapleigh for about eight years, he located in Springvale where, except for a brief time spent in Lynn, Massachusetts, he resided and practiced up to the time of his death.

Doctor Bragdon was an honorary member of the Maine Medical Association having received the Association's Fifty Year Gold Medal at the 1933 Annual Session of the Maine Medical Association held at Poland Springs.

Other highlights in the career of Dr. Bragdon were his being honored by 10,000 people on the occasion of "Doc" Bragdon Day at Acton Fair last August and a testimonial dinner tendered him by fellow practitioners at the Henrietta D. Goodall Memorial Hospital, Sanford, on the occasion of his celebrating his 50th year in the profession.

Dr. Bragdon had been one of the most prominent devotees of light harness racing in this section of Maine since 1898. He was long a familiar figure on ovals throughout Maine and on many New England tracks.

Dr. Bragdon was a Past Master of Springvale Lodge, A. F. and A. M., a member of White Rose Chapter, Royal Arch Masons and Friendship Lodge of Odd Fellows.

Surviving him are his wife, two sons, Fred R. of Wells and Harry B. of Berwyn, Illinois, two daughters, Mrs. Lena B. Ferguson of Ludlow, Massachusetts, and Mrs. Florence Morrison of Springvale, and several grandchildren.

Notices

Notice of Child Health Day on May Day 1939

In accordance with the Congressional Resolution of May 18, 1928, which authorized the President to proclaim May Day as Child Health Day, the Children's Bureau at the request of the State and Provincial Health Authorities of North America are sponsoring Child Health Day Activities the 1st day of May this year. Through the pages of our *State Association Journal* the interest of our physicians in this program is solicited. Newspapers within our State and elsewhere have published statements concerning the nutrition of large numbers of children within our border which challenge not only our child welfare achievements but also our efforts and accomplishments as practicing physicians.

Is this not an appropriate time, then, for us to review the child health activities in our communities and to support sound and well planned programs for extension and improvement of them?

The Health of the Child is the Power of the Nation

American Association for the Study of Goiter

The next annual meeting of the American Association for the Study of Goiter will be held in Cincinnati, Ohio, May 22nd, 23rd and 24th. The program for this three-day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics conducted by guests of the Association, and operative clinics in the various hospitals in Cincinnati.

For further information write to the Corresponding Secretary, W. Blair Mosser, M. D., Kane, Pennsylvania.

*Tumor Clinics**

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 10.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital*—Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital—Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Philadelphia Academy of Surgery

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It is expressly stipulated that the competitor who receives the prize shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery, and that on the title page it shall be stated that to the essay was awarded the Samuel D. Gross Prize of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to the "Trustees of the Samuel D. Gross Prize of the Philadelphia Academy of Surgery, care of the College of Physicians, 19 S. 22d St., Philadelphia," on or before January 1, 1940.

Each essay must be typewritten, distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

EDWARD B. HODGE, M. D.,
CHARLES F. MITCHELL, M. D.,
CALVIN M. SMYTH, JR., M. D.,
Trustees.

Philadelphia, February 1, 1939

The Balkan Medical Union

The Balkan Medical Union, in session at Istanbul, for the 5th Medical Week,

having taken into consideration the terrible sufferings which a total war will bring upon the civil population of open towns together with the total lack of any adequate means of protection,

and having discovered that even in its restricted form the project of "sanitary towns" has not yet been adopted, and that all efforts made to protect civilians against chemical warfare have till now remained as proposals only, and that even the protocol prohibiting the use of asphyxiating gas has not yet been ratified by all nations,

has therefore decided to address itself to doctors of every nation with an appeal to take active measures and to fulfil this professional and humanitarian duty of awakening and stirring public opinion.

The Balkan Medical Union believes that only enlightened international opinion can make plain the imminence of the danger and the proved uselessness, even for the victor, of these terrible atrocities, and can thus lead to effective action.

The immutable truth that

hate breeds only hate, and atrocity breeds vengeance must be impressed on everyone.

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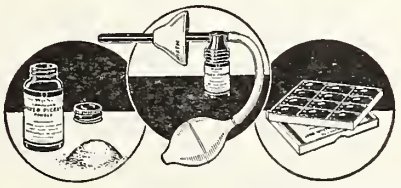

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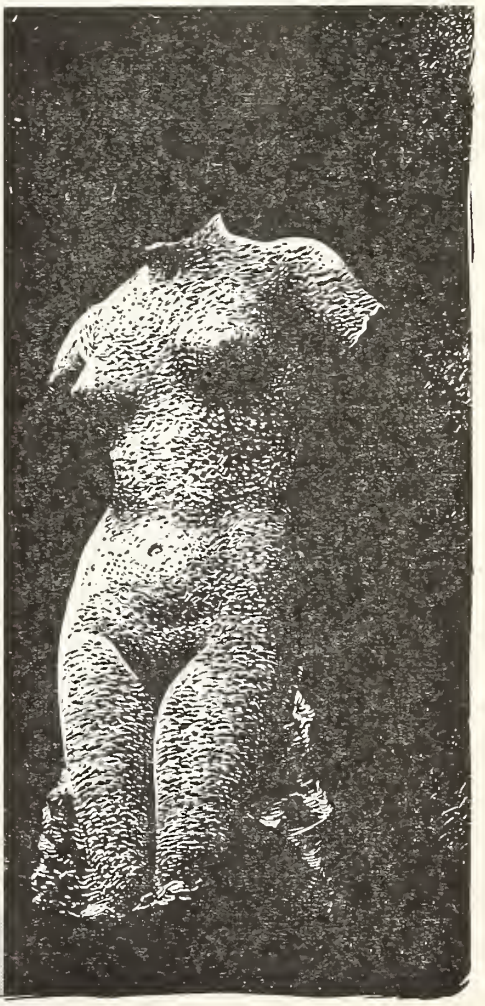

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"Doctor Bradley Remembers"

By Francis Brett Young. Published by Reynal & Hitchcock, New York, 1938. Price, $2.75.

During the recent years a considerable number of good novels depicting the life or lives of the family physician have been written. The book under review tells the story of Dr. Bradley, a general practitioner of Sedgebury, Mr. Young's beloved, smoked-grimed Black Country in England. It tells of the times when the long glowing spark of medical heroism suddenly burst into flame and fired such men as Lister, Koch, Pasteur, Cushing, etc., with new enthusiasm and carried them to undying fame.

In charming, easy flowing language, the reader is told of the various obstacles which John Bradley had to overcome, how, with all the expenditure of his energy, he could reach but mediocre success, how he was, from birth till death, destined to fight adversity almost always alone. Realizing his own shortcomings, he hoped that some day there would be a better doctor than he could be to succeed him and with special effort he tried to raise his son for the noble profession, quite contrary to the latter's own inclinations, however.

Finally after having survived the various shocks that fate dealt him, he, having tried to find forgetfulness by working harder among the poor, decides to sell his practice. Bent over his well kept daybook one evening, having written "paid" after the last entry, he fell into a state of reminiscent meditation. A rich life it was, full of hard work, some happy moments, many sorrowful years. Inwardly he is satisfied in the feeling that he had always done what he thought to be right, now after fifty years of practice, he suddenly discovers that although his book was well filled with entries and in final order, he knew not how long his aging aching body could survive on his exceedingly small saved up reserve fund.

Though physically tired, his spirit was now wide awake. With lightning rapidity it carried him through most of his seventy odd years. Mr. Young, himself a physician I am told, catches Dr. Bradley's every thought and presents it in a true-to-life manner that appeals to every adversity battling life asserting soul. In Dr. Bradley Remembers, Francis Brett Young seems to be at his best.

"What's Wrong With Me"

By H. Ameroy Hartwell, M. D., Fellow of the American Medical Association; Fellow of the New York Academy of Medicine; Member of the Medical Society of New Jersey, The Hudson County Medical Society, The North Hudson Physicians' Society, The W. H. Lucket Clinical Society, The American Heart Association, etc.

Published by the County Life Press, Garden City, N. Y., 1938.

The purpose of this book, written expressly for the general public, is to provide the reader with a simplified terminology of the symptomatology of a great variety of diseases. The author believes that by the encouragement of self-analysis the patient will become conversant with terms roughly describing his complaints so that he may intelligently present his case to his physician. The material is alphabetically arranged. The general description of the characteristics, symptoms and causes of each disease take up about one page. 288 diseases are described.

The author believes that, "If you have the symptoms enumerated in five or more lines under any of these diseases, you may conclude that you are probably suffering from that disease; but verify your opinion by consulting your physician in time to establish a correct diagnosis by his physical findings."

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*Communicable Disease Hospitals**

By D. L. Richardson, M. D., Superintendent Charles V. Chapin Hospital, Providence, Rhode Island.

The evolution of the hospital for infectious diseases has paralleled the acquisition of knowledge concerning infectious diseases, their modes of transmission, the occurrence of extensive epidemics of certain highly transmissible diseases, and both the intellectual and financial progress in different countries. It should also be emphasized in the beginning that institutions for the segregation of contagious diseases could hardly, with few exceptions, be called hospitals unless they have been built within the last fifty or seventy-five years, and that even primitive places of isolation date no further back than the fifteenth century.

During the Middle Ages, Europe was overrun with leprosy. This disease, long before this period, was recognized as a contact disease and an effort was made in different European countries, particularly in France, to segregate lepers in isolation hospitals called lazarettos. This name for isolation hospitals still survives in some Latin countries. Some 2,000 institutions for their segregation were erected of which 1,500 were located in France. Since the diagnosis of leprosy was not always accurate, cases of syphilis and other skin diseases were often included. Leprosy subsequently began to disappear either because of isolation of cases or due to some change in the virulence or invasiveness of the disease. In reading the history of this period, it seems that the isolation of lepers should be given chief credit because the disease disappeared from Europe except for occasional cases in Norway and in countries bordering on Asia, whereas it still persists in Asia and other eastern countries where isolation of lepers was not carried out or only to a very limited extent.

The destructive wave of plague through Europe in the fifteenth century was another occasion when temporary quarters for isolation of cases were erected in different European countries. At other periods, epidemics of typhus fever, cholera, and smallpox compelled the building of isolation hospitals.

Out of these experiences, the more progressive countries in Eastern Europe began the erection of more permanent isolation hos-

* Read before the Fall Clinical Session of the Maine Medical Association, at Lewiston, November 3, 1938.

pitals. Among the earliest of these institutions was the London Smallpox Hospital established in 1745, the Lock Hospital for venereal diseases in 1746, and the London Fever Hospital in 1802. All these institutions were founded by private effort, not so much with the idea of controlling the disease as for providing the afflicted persons with adequate medical and nursing care. In fact, the first Public Health Act of 1848 contained no provision to allow the local boards of health to provide hospitals for infectious diseases. Such a provision was passed in 1866. Even at that time, knowledge about how infectious diseases were transmitted was quite vague. The early sanitary reformers were inclined to look for their origin in foul air, soil and water supplies rather than person to person infection.

Strange as it may seem, about this time there was considerable difference of opinion relative to the advantage of caring for contagious patients in fever hospitals or of distributing cases in the wards of a general hospital. In both England and France, it was a fairly general practice to admit a limited number of contagious patients to general hospitals. There was a feeling that it was safer for patients, nurses, and the other hospital officials not to concentrate too many patients in one hospital because of the danger of "concentrating" the poison. Out of this controversy developed a new interest in infectious diseases and this was given further impetus in England by investigations of conditions in the Poor Law Infirmaries and the outbreak of a very severe type of scarlet fever in the early sixties. On the one hand were physicians who thought it was a crime to establish special isolation hospitals while on the other a more progressive group, who made careful studies, defended such hospitals.

The outcome of this controversy was that in the early seventies, an extensive program of construction of isolation hospitals in London and other English cities was established with the idea that if all cases of these transmissible diseases could be taken out of the community, diseases like scarlet fever and diphtheria could be eradicated. In this latter respect, they were wrong but the hospitals did provide much better care for those who were ill with infectious diseases and such isolation did help to control epidemics even though it did not eradicate them entirely.

All this took place before any disease-producing germs had been discovered. In the light of our present knowledge, the establishment of infectious disease hospitals was a decided forward step. As the bacterial causes of different infectious diseases were discovered during the last quarter of the nineteenth century, control of these diseases could be planned from exact knowledge as facts became available. Pasteur, Koch, Loeffler and other bacteriologists by their discoveries opened up a new era in public health and the administration of contagious disease hospitals.

Even after the cause of some of the infectious diseases was discovered, the idea that they were disseminated through the air persisted. There was some justification for such a belief because disease-producing germs could be recovered not only from the patient, the ward furniture, floors and elsewhere, but also from the air. All kinds of bacteria could be grown on media plates exposed to the air in contagious disease hospitals. It is not to be wondered at that isolation hospitals constructed late in the last century and in the early years of the present century were of the pavilion type of construction with only one disease being cared for in the same building or in a single ward. Whenever the buildings were more than one story high, care was taken to provide separate entrances for each floor and to avoid the installation of ventilating and heating ducts which opened into both wards.

It does seem rather strange, however, that the transition from the antiseptic to the era of asepsis did not make more of an impression on those conducting isolation hospitals. Surgeons soon learned that antiseptic sprays were unnecessary and that the bacteria in the air were usually saprophytes and that disease-producing organisms were comparatively few in number.

The credit for demonstrating that atmospheric transmission of infectious diseases was of little consequence in the hospitalization of infectious diseases should go to Grancher of Paris, visiting physician to the Hospital for Sick Children. This was a general hospital for the care of children. The

wards generally were large and contained patients who were ill with many kinds of diseases. On the Continent as well as in England, some general hospitals at the time admitted a limited number of acute transmissible diseases. About 1890, Grancher began to admit to these general wards, cases of scarlet fever, diphtheria, and measles. He isolated such patients in the ward by surrounding the bed with screens, providing gowns and nursing utensils within the screened area, and required that the nurse and doctor should remove the gown and scrub hands before leaving the enclosure. All utensils used in the enclosure were sterilized after being removed. An antiseptic solution was used on the hands. For a period of about ten years he kept up this administration experiment and concluded that scarlet fever and diphtheria were scarcely ever carried through the air and that even measles infection was rarely disseminated in this manner.

About 1895, Roux, health officer of Paris, recognized the significance of these practical experiments and through his efforts the Pasteur Hospital was completed in 1900. This was the first hospital in the world to be constructed for the care of different infectious diseases on the same floor. Each ward floor consisted of single rooms and a large room divided into four compartments by partitions six or seven feet high for the care of convalescents. Each room was provided with a lavatory and sink for the convenience of the nurses in carrying out the technique. Patients were confined to their rooms and the aseptic technique was rigidly carried out to prevent disease-producing germs from being transmitted from one patient to another. A concession to previous ideas was made by the construction of narrow balconies along the outside of the building at each floor level and doors were located to allow entrance and exit from each room to these balconies. The method of transmission of typhus and some other diseases had not been discovered and the provision of the balconies and doors made it possible to close the corridor doors so the nursing service could be carried out through balcony entrances. Actually, this practice was never employed and the balconies have been used to allow visitors to view the patients in their rooms.

Since this hospital was opened, the incidence of cross-infection has been very low, a fraction of one percent. All kinds of infectious diseases, including smallpox have been cared for simultaneously in these wards. The actual experience in the wards of the Pasteur Hospital proved conclusively that contact diseases are not, except in rare instances, transmitted through the atmosphere.

Soon after the opening of the Pasteur Hospital, some of the London fever hospitals cautiously began to introduce aseptic nursing. The English contagious disease hospitals of that day cared for patients, for the most part, in large wards. Some of these were cut up into cubicles with seven-feet high partitions between rooms and between rooms and corridor. Considerable trouble had been experienced with return cases of scarlet fever and these cubicles were first utilized for the isolation of cases for 48 hours before discharge. Subsequently these cubicle wards were used for the isolation of miscellaneous diseases. The results were similar to those reported from Paris and since that early experience, older contagious hospitals have been reconstructed and new ones built to make it possible to care for different diseases on the same floor and equipped to make the nursing technique as simple as possible.

The earliest contagious hospitals in this country were built for the care of smallpox and were called pest houses. These wooden structures which were widely distributed for smallpox had been quite common from early colonial days. These were used only when the disease was prevalent. They could hardly be called hospitals. Usually some dwelling outside the town was purchasd for the purpose and when the disease appeared, the temporary employees were recruited to care for the patients.

Subsequently the larger cities built permanent hospitals for the care of scarlet fever and diphtheria and other diseases were accepted to a limited extent. Following the practice in Europe, these hospitals were of the pavilion type for the most part, each pavilion designed for a single disease. In most of the earlier hospitals of this type, the medical and nursing service and the hospital equipment was inferior to that supplied by the contemporary general hospitals. Even

up to quite recently, an isolation hospital has been looked upon as a place of segregation. Little thought or interest was shown in providing good medical and nursing care. The public was not interested in what happened to the patient as long as he was removed from the community.

In 1910, the Providence City Hospital, now known as the Charles V. Chapin Hospital, was completed and here it was that aseptic nursing was first tried out in this country. One ward was used for scarlet fever and one for diphtheria patients while others were used for miscellaneous diseases. A very exacting technique was planned and carried out. Essentially the technique is the same now as that employed in 1910 although it has been simplified considerably. Now the wards are almost all for miscellaneous diseases, with the exception of scarlet fever, there are not enough patients suffering from one disease, except during epidemics, to keep one ward busy.

A very careful record has been kept of cross-infections for twenty-eight years. These have always been recorded in the annual report. The cross-infection rate has been variable. It has exceeded two percent in six of the twenty-eight years and for several years it has been about one-half of one percent.

When the writer first began to read papers about aseptic nursing, the older superintendents were very courteous but very incredulous. Such a method could never succeed in their estimation. Success was attained and the isolation of miscellaneous diseases on the same ward floor by following rules of asepsis has been generally accepted in this country.

When cross-infections do occur, they are almost always cases of chickenpox and measles. These are the only two diseases which require special consideration except that whenever smallpox is admitted, all patients on the ward are revaccinated.

Since it has been demonstrated that air transmission of infectious diseases is of little consequence, the modern infectious disease hospital is quite different from the old contagious hospital. It is usually built of brick and more than likely is stories in height except in the smaller cities and towns. If there are enough patients suffering from scarlet fever, for instance, then one or more wards are reserved for that disease. When outbreaks of measles or acute poliomyelitis occur, the cases are concentrated in separate wards to facilitate treatment and nursing care. Other wards are reserved for miscellaneous diseases. All wards, however, should be so constructed that no more than six patients are cared for in a single room. In larger hospitals, old wards of greater capacity are divided into cubicles or beds, are separated far enough apart to keep patients from direct contact and these are particularly useful for infants and small children. It is essential to make it impossible for patients suffering from different diseases to come in direct contact and the number of patients in each unit should be few so that if a cross-infection does take place, secondary cases will be limited.

It is extremely important that the physicians in charge of infectious disease wards shall have experience in diagnosis so that only patients suffering from the same disease will be put in the same unit. Cases with a doubtful diagnosis should always be put in a separate unit until a diagnosis can be made. Resident physicians should follow the patients very carefully in order to detect at the earliest possible moment the onset of a second disease or some infectious complication.

The nursing procedure may at first glance seem to be complicated but the principle underlying each procedure is much like the technique observed in the operating room. Infection is confined to the rooms occupied by the patients. Everything which is taken from the room must be properly cleaned or sterilized. The hands of the physicians and nurses must be scrubbed for at least two minutes with soap and water. It is seldom necessary to use a disinfectant. Gowns are worn if an examination or nursing procedure is of such a nature that clothing might come in contact with the patient or anything in the room. Each room should contain a lavatory where the water can be turned on by forearm or elbow, knee or foot, and the hands should be scrubbed in running water of suitable temperature.

The kitchen and service room should be equipped with utensil sterilizers and clothes chutes for used linen so that it will not be left on the ward between collections. Infectious diseases are usually transmitted by

direct contact or indirect contact when hands or nursing utensils are contaminated with fresh secretions. For this reason, the nursing technique should be rigidly carried out and to make it uniform throughout the hospital, all procedures should be in printed form and supplied to all physicians and nurses.

Certain precautions should be observed in the disposal of used linen, the supplying of the wards with food and drink, and other contact of the service portions of the hospital and the wards. The danger from such indirect contact, however, is very slight and the technique involved is very simple. It is important that the hospital personnel be under careful observation to detect the onset of infectious diseases at the earliest possible moment. Otherwise they might distribute the infection to other members of the hospital staff and to patients if they are on duty when in an infectious state. All these precautions, in a general way, are carried out in all modern infectious disease hospitals and by their faithful execution, the danger of secondary diseases occurring among patients and hospital personnel is slight.

Since it is feasible to care for different transmissible diseases not only in the same building but also on the same floor, it makes it possible for even the smaller cities and towns to provide isolation hospitals. Previously, even in the larger cities, isolation hospitals found the number of patients so reduced seasonally that a large part of the hospital capacity was unoccupied, even though the employees had to be kept on the payroll. This also made the expense, particularly the per capita expense, very high.

Another change has been noted. Formerly contagious hospitals limited their admissions to scarlet fever, diphtheria, and smallpox. From the beginning, the Chapin Hospital accepted for treatment any kind of transmissible disease including typhoid fever, pneumonia, poliomyelitis, epidemic meningitis, erysipelas, and other diseases which were then admitted to general hospitals. Gradually general hospitals have been turning these cases over to the isolation hospitals. This change has taken place quite generally over the country. The general hospitals feel that they are not properly equipped or staffed to take a chance with transmissible diseases unless it is absolutely necessary.

To correct the poor service in isolation hospitals and to reduce the expense, in 1929 a resolution was passed by both the American Hospital Association and the American Public Health Association to the effect that in cities of less than 100,000 population, the local isolation hospital should be located on the grounds of a general hospital. This resolution could not have been passed years ago because of the fear of air infection and imperfect administration of the isolation units. The reasons advanced for this resolution were that it would be cheaper, that the patients in the isolation wards would have the benefit of the services of specialists, better hospital facilities such as X-ray, laboratory and operating facilities, and other services so lacking in the older isolation wards. Moreover, such wards would be of great service for the isolation of many kinds of infections which are constantly arising in any general hospital. These wards would be invaluable for the training of internes and student nurses.

As a matter of fact, every general hospital should have a few rooms or a ward, depending on its size, for the isolation of transmissible diseases. These rooms should be for a single patient and each room should have a lavatory and the ward should be provided with utensil and dish sterilizers so that aseptic nursing can be easily carried out. Such an investment will help to prevent infections which not infrequently occur in general hospitals and especially hospitals for children.

If the general hospital in any city or town is a private hospital, as is usually the case, the city can pay for this service at much less expense than to maintain a separate hospital. The larger cities can well afford to build and maintain isolation hospitals which are as well equipped and well staffed as modern general hospitals and there are many of these now in existence. By the arrangement already described, it is possible for smaller cities and even rural districts, because of the automobile and good roads, to be equally well served.

Thirty years or more ago, to serve in an isolation hospital necessitated almost com-

plete isolation from the community. Nurses and employees, and sometimes even resident physicians lived in the patients' pavilions. When they were allowed to leave the hospital, it was only after bathing and donning a complete change of clothing. From the beginning at our hospital, physicians, nurses and employees have lived under the same conditions as those employed in general hospitals and this is generally practised in this country.

Thirty years ago, with a few exceptions, student nurses never received training in contagious wards. The training schools, largely because of objections from parents of student nurses, would not allow affiliation with isolation hospitals. As a matter of fact, there was considerable justification for this attitude because illness among internes and nurses was very common and not infrequently very serious. When aseptic nursing was introduced, the amount of illness decreased remarkably.

At the Chapin Hospital last year, where about 350 student nurses served a three-month training period, three contracted scarlet fever, one rubella, and one chickenpox. These were the only cases of infection contracted among the entire personnel. Internes scarcely ever contracted infection from patients. On the average there has been only about one case a year among physicians and sometimes several years may elapse without any infections. Of course, there always is such a possibility in spite of all precautions but such infections are so infrequent that there is no longer any real fear of serving in an isolation hospital.

Reference should be made to the work of Dr. and Mr. Wells at the Harvard School of Public Health. They have been working with ultra-violet light to kill bacteria in the air. They have developed a new suction apparatus for collecting organisms from the air. It has been found that exposure to ultra-violet rays will kill bacteria in the atmosphere. These lights have already been installed in some operating rooms and experimentally in two or three hospitals.

Some disease-producing bacteria can be recovered from the air. This is not a new scientific fact. However, even if they can be recovered, this is no indication that they are really a source of infection except rarely. Actual experience in operating rooms and hospitals over a period of many years clearly demonstrates that infections from the air are rare. The use of these lights revives the belief in atmospheric transmission and especially in infectious disease hospitals it is likely to undermine the quality of aseptic technique for contact, after all, is practically the only way that disease-producing bacteria are transmitted.

So far there has been no available statistical data to show that the introduction of ultra-violet light has reduced the incidence of operating room infections or cross-infections in the wards of isolation hospitals. During this year just closed, there was only one case of cross-infection, a case of chickenpox, at our hospital. This is the lowest rate that we have ever had. Had we employed ultra-violet lights in the wards we probably would give them some credit. They are expensive to buy and expensive to maintain, and they offer some administrative difficulties. While we have not tried them, I am quite sure from many years of experience with contagious diseases that they have little to recommend them.

Hospitalization of acute transmissible diseases will not stamp them out. There are as many cases of scarlet fever and diphtheria in London as there were fifty years ago. These diseases are milder and much better cared for, lives are saved, and isolation has a steadying effect on outbreaks. The expense necessary for the best of medical and nursing care of acute infectious diseases, particularly the more serious ones, is more than justified from the standpoint of life-saving alone to say nothing of the welfare of the individual patient and the community.

The past fifty years may well be called the Golden Era of Medical Progress. It has been a great privilege to have lived during this period and to have observed and taken even a small part in what has been accomplished. Not the least of this great improvement has been the introduction of more scientific measures for the control and treatment of acute infectious diseases.

*Syphilitic Epilepsies (Their Frequency and Treatment)**

By L. Babalian, M. D., Portland, Maine

Since the works of Fournier, written over half a century ago, the syphilitic nature of some cases of epilepsy is no longer doubted. Syphilis is responsible for some cases of infantile epilepsy, so-called idiopathic. Syphilis can, in adults as well as children, create all forms of epilepsy:

(a) major attack of haut-mal with generalized convulsions and with or without the initial cry;—

(b) slight attack of petit-mal, such as absences, jerking, dizziness, fainting;—

(c) partial attack; so-called Bravais-Jacksonian, either intermittent, or becoming generalized, or continuous, and leaving after effects of slight paralysis;—

(d) epileptic equivalents; either psychic paroxysms such as ambulatory automatism, or sensorial equivalents (hallucinations of taste, smell, etc.), or visceral equivalents (migraine, nausea, enuresis, etc.).

These are well-known facts, and no pathological treatise exists which does not mention them more or less fully.

Besides these different forms of epilepsy syphilis can also be the cause of epileptiform troubles, such as laryngeal ictus of locomotor ataxia, such as the compressive troubles due to cerebral gumma or to osteo-periostitis of the inner table of the skull.

I only mention these manifestations wishing to call attention to certain points.

* * * * * * * * * * * *

Since Fournier authors have faithfully reproduced the picture he drew of syphilitic epilepsy. As he did, they also insist on certain clinical details which would stamp the luetic origin of these symptomatic epilepsies. These would differ from true epilepsy, so-called idiopathic, by their later appearance, their resistance to the nervine medications, their ending sooner in insanity. All these distinctions are debatable, and mean nothing, because syphilis can be the cause of all clinical types.

Syphilitic epilepsy besides can be associated with other manifestations of cerebral syphilis: cephalaea, cranial paralysis, tabes dorsalis, general paresis. But it is evident that one must not wait for these manifestations before diagnosing epilepsy as syphilitic.

To summarize, syphilitic epilepsy has no clinical character which belongs only to it, and cannot be differentiated from so-called idiopathic epilepsy, an entity which is moreover in doubt.

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A point on which controversy rages among authors is the frequency of syphilitic epilepsy. Fournier thinks that when it is not a question of idiopathic epilepsy, eight times out of ten, it is luetic. Gougerot goes even further; according to him syphilis is responsible for a great many cases of idiopathic epilepsy. As a general rule syphilitic epilepsy is considered rare; it is found in seven percent (Viet) or five percent (Bratz and Luth) of cases. According to Stokes, the proportion of syphilis in epilepsy varies a great deal with the date of its appearance; in the adult types from two to three percent have positive blood Wassermann, while in children twenty percent.

If the role of syphilis is generally unestimated in epilepsy, that is because of three reasons:

First, in nervous syphilis dystrophic stigmata (osseous, dental, etc.) are rare and often absent. Their absence is even so frequent that some authors raise the question of whether the virus of nervous syphilis is the same as that of dystrophic syphilis.

Secondly, specific treatment is usually without effect because, when epilepsy is clinically apparent, that is the result of a neuroglia sclerosis which is a definite and irreparable lesion. The therapeutic test is here without value.

Finally, a negative serology in blood is extremely common in congenital syphilitics; that is a well-known fact and does not mili-

* Presented at the Staff Meeting of the Maine Eye and Ear Infirmary on December 15, 1938.

tate against syphilis in epileptic children. The examination of the cerebrospinal fluid gives perhaps truer information. However, it is not rare to find a cerebrospinal fluid normal in old stationary nervous syphilis. Even in recent cases, if the lesion is sub-cortical and therefore at a distance from the meninges, as it is often the case in idiopathic epilepsy, the cerebrospinal fluid can be found normal.

To establish the syphilitic nature of an epilepsy, nothing remains to do in several cases but a minute inquiry into the family history. To prove this point take for example the case that Dr. B. B. Foster and I observed recently.

G. S. Boy 8 years old. Born at term without forceps. At about two years appeared convulsions which recurred during several months and gradually gave place to true epileptic seizures. He was examined several times for syphilis, but this was not recognized because of negative Kahn. For six years the disease was considered an idiopathic epilepsy with seizures once or twice a week in spite of phenobarbital and bromides. Each seizure lasts from one to four hours, some of them so serious as to necessitate prolonged inhalations of chloroform. In addition, during the past year, modification of disposition; the child is more and more stubborn, cannot concentrate, remains in a state of complete ignorance and sometimes utters inarticulate cries.

Finally there appears an intersitial keratitis; the child is then sent to Dr. E. E. Holt, Jr., who demands, with good reason, further examination from the standpoint of syphilis. This new examination reveals no characteristic stigmata and nothing in the blood. But an interview with the mother brings to light some interesting facts. She has had before this child, three other children all of whom died in infancy. After a long interrogation she admits having had before her marriage a chancre on the upper lip for which she had been given only four intravenous injections. Moreover, her blood is found strongly positive.

There is no longer any doubt that this case of so-called idiopathic epilepsy is in reality a clear case of luetic epilepsy, in spite of the absence of stigmata and negative blood tests.

Conclusions

Syphilitic epilepsy is not as rare as the majority of authors would have us believe. Hereditary lues seems to be a frequent cause and should be sought by every kind of examination, especially by a complete family inquiry.

There are, however, many cases where no traces of syphilis can be discovered; but there again it must not be ignored systematically. If one considers the dark future of many epileptics, one has the right to try a specific treatment in all these cases, because it is better there to sin by commission than by omission. But specific treatment can only have effect in being given at the outset of the disease, before the appearance of neuroglial sclerosis. One must then treat epilepsy, not when it is evident clinically, but in its prodromic stage. This stage, in child epilepsy, is precisely that of the first convulsions in infancy, after which the convulsions cease and are followed generally by a period of deceiving calm. And it is only after several months or even years that appear the first signs of epilepsy. At that time it is too late to treat. The ideal way would be therefore to give a specific treatment as soon as the convulsions of infancy occur. I don't mean that specific treatment should be given in all cases of convulsions. We must eliminate the cases due to obstetrical cranial injuries, and those more numerous and generally with fever, where convulsions are connected with toxi-infectious diseases. There remains a certain number of cases where the nature of convulsions cannot be determined exactly. In these cases one has the right to and should give specific treatment.

The problem takes a different form when epilepsy has become evident due to an irreparable lesion. Specific treatment should, however, be tried, less with the hope to improve the disease than to limit the damages. In that case it seems prudent to use only bismuth or mercury; because arsenic, strong vaso-dilatator, could favor the appearance of epileptic seizures, or even congestive and hemorrhagic lesions in the central nervous system, lesions which epilepsy already tends to produce.

May Day as a Child Health Day

By Robert E. Jewett, M. D., Chairman State May Day Committee

We are indebted to the barbaric Celts, who inhabited the British Isles two thousand years ago, for two time-honored traditions, Mistletoe and May Day. Mistletoe was a ceremonial object which captured the imagination of that primitive Aryan people, because it had no roots in the polluted earth and grew magically, high up in the branches of the oak tree, suspended between heaven and earth. Cut down with a golden sickle in the hand of a priestly Druid, it was used to make potions for the fertilization of barren women and cattle.

The May Day of the Celts was heralded as the first day of spring, and the people led by the Druids celebrated it in wild, if ceremonial, revelry to stimulate the magic fructification of the land. Nothing was more wonderful to those barbaric tribes than the magic appearance of buds upon the trees and the bursting forth of fresh green shoots from the dormant earth. Equally as important, and far more wonderful, was the propagation of their flocks and herds. The fundamental nature of procreation remains a mystery, even to modern scientists; so that it is small wonder that primitive peoples beheld it with religious awe.

Two thousand years have passed, and great changes in the customs and traditions of the races of man have come about, since the Celts celebrated the first day of Spring, at places like Stonehenge, in England. The rise of Christianity was most important in bringing about these changes, and May Day came to be celebrated in a spirit of wholesome joy at the passing of winter, and the beginning of spring, even as the wild revelries of the Saturnalia were forsaken for a day of reverent observance of the birth of the Christ by peoples around the Mediterranean.

As a festival characterized by may-pole dances, and the distribution of flowers by throngs of happy children, May Day has been a long and pleasant tradition among English-speaking people. For generations its connotation has been one with new green grass, blooming flowers, and the happy laughter of children, joyous at the new life being unfolded before them.

However, if May Day did become a tradition of beautiful and wholesome import, there remained a shadow of irony unheeded till the present century. Ironically enough, the Celts stood in awe of the laws of procreation, yet took the welfare of growing things as a matter of course; but this blind-sidedness was no more unreasonable than the joyous heralding of spring by laughing children, who in reality were hailing the hot, pestilential months destined to destroy countless numbers among them.

Winter has always taken its toll of lives by respiratory diseases and nutritional deficiencies, but summer, with its hordes of flies, and scourge of putrefaction, has purged out the lives of millions of infants up to and including the beginning of the twentieth century. There are many now living who can recall the swathes cut in the ranks of year-old infants by the scourge called "second summer complaint," a disease we now give the name of "infectious diarrhea," and ward off by the simple expedient of carefully handling the baby's food.

For centuries, now, man has realized the importance of carefully cultivating his growing crops, and safeguarding the health of his newborn animals; but the full realization of his responsibility for the welfare of his own offspring, to say nothing of the mothers who bore them, has only been brought about by the phenomenal advancements in medical science in the last one hundred years.

The first real step towards a definite consideration for mothers was suggested by the works of Holmes and Semmelweiss, in the nineteenth century, but it remained for the last few decades to produce a definite movement towards the safeguarding of the newborn infant and the growing child. The doctor has fought his battle against invading disease for many more years, but national and international interest in disease prevention is comparatively recent.

National interest in child health has

arisen, and mankind should bow its head in confessing it, as much from economic and social demands as from simple humanitarianism. A rising death rate in the face of a falling birth rate incident to war, and the financial pressure of an economic depression, are factors which bring an entire nation to realize the importance of protecting life and health, in order that society's ranks may not be depleted, nor a costly burden of caring for the indigent sick be thrown upon the state.

General disgust at "child labor" injustices during the last century gave physicians and farseeing crusaders an entering wedge for interesting society at large in generalized child health work. The origin of the Children's Bureau, and even the Department of Labor, of the federal government was indirectly due to the national feeling aroused by this movement.

In 1916 the President endorsed the first Nationwide Baby Week, and Julia C. Lathrop, first Chief of the Children's Bureau, in her annual report of that year, suggested that May Day "might well be chosen as a day for the celebration of the increase in the common store of practical wisdom with which the young life of the Nation is guarded by each community."

Many people helped to bring about the celebration of May Day as a day for assessing child-health needs, and in 1928 a congressional resolution authorized the President to issue an annual May Day proclamation. In 1935 the Association of State and Provincial Health Officers of North America asked the Children's Bureau to sponsor May Day Child Health Day, and 1939 represents the fourth year of its sponsorship. However, celebrations in the states are largely due to the coöperative work of schools, local community groups, and the state health departments.

In planning objectives for May Day Child Health Day programs, there are many problems which might be taken as meriting the attention of the people of the State. For example, one might stress the importance of comprehensive ante-partum care for the mother to the survival and well-being of the unborn child. In the State of Maine, nine hundred to a thousand infants die before reaching the end of the first year; and these deaths constitute nearly one-tenth of the total mortality. One-third of the infant deaths are due to premature birth, and an additional four hundred infants are stillborn; both figures being due, in part at least, to causes incident to the ante-partum period. The medical profession is fully conscious of its responsibilities, and it is awake to the need of combating the causes of these deaths, toxemia, malnutrition, and intercurrent disease, to name a few; but the public needs to be awakened to the importance of ante-partum care, and mothers made to realize their own responsibility to their unborn babies.

If by one May Day program we could make the importance of ante-partum care universally understood, we would undoubtedly reduce the two biggest factors in the infant death rate to a figure lower than ever before achieved. However, progress in these matters can only come by a slow process of education, and many other problems must occupy part of our time. Therefore, we must content ourselves with taking a small cut at the many risks which beset the growing child.

The State May Day Committee, in planning its program for 1939, has decided that it will not stress any child health problem to the exclusion of others. The coöperation of local groups, clubs, schools, and health agencies will be sought in carrying out a program designed to instruct children and parents in the importance of good health and ways of safeguarding it. These local activities will include health plays, pageants, and educational talks by qualified speakers. In addition, since the incidence of diphtheria has been high in Maine the past year, the Committee urges that immunization clinics for the administering of toxoid be sponsored by local groups, arrangements to be made through the District Health Officer.

The planning and execution of a program of health education for May Day Child Health Day is a humble start towards a solution of the many child health problems, but it is a start. The May Day of 1939 is a far cry from the May Day of the Celts, and it is a glorious thing that our eyes may be turned from the wonders of the present to a comprehending view of the needs of the future. Let us remember the words of the 1939 May Day Slogan, "The Health of the Child is the Power of the Nation."

The President's Page

To the Members of the Maine Medical Association:

President Bunker has asked me to pinch-hit for him this month, and I thought that many, especially the Medical Examiners, would like to know how the Medical Examiner's Bill is getting along.

The Bill was drawn up by Attorney General Burkett, introduced by Representative Peter Mills, and referred to the Committee on Legal Affairs.

The Attorney General made an excellent argument for the Bill at the hearing before the Committee.

There was some opposition, and several amendments were suggested.

The Committee reported promptly and unanimously that the Bill ought to pass without amendment.

The House passed the Bill with an amendment allowing the present Medical Examiners to serve out their terms, and another allowing police officers to remove a body from the highway or similar place, before the arrival of the Medical Examiner.

The Senate refused to accept the first amendment, and the House refused to recede. Therefore the Bill was referred to a joint Committee which we hope will be able to agree, and it would seem that it should, as the point on which there is disagreement is of no great importance.

George L. Pratt, M. D.,
President-Elect Maine Medical Association

Editorial

Sulfanilamide in the Treatment of Gonorrhea

The clinical problem of the treatment of gonorrhea is just as important today as before the discovery of sulfanilamide and its therapeutic value in this disease. Unfortunately the publicity associated with the drug has conveyed the erroneous impression, shared alike by the laity and some of the profession, that today gonorrhea is a mere unpleasant inconvenience and easily cured by the widely-publicized sulfanilamide. This is a most dangerous belief, since the cure of gonorrhea and hard clinical proof of that fact is not as simple as many enthusiastic reports would have us believe. Remission is far from a cure and clinicians of experience know full well that the immediate and distant morbidity of the disease is serious and remotely, in the female, carries a definite mortality. This mortality arises from the serious pelvic conditions, occurring in no small percentage of carefully treated cases, since these sequelæ require radical surgery for their cure. The time of this demand is often in the best years of a woman's life and when required many times results in the complete sacrifice of the organs necessary for procreation and well being. The operation from a surgical standpoint may achieve complete success, but it often leaves a patient crippled from the standpoint of mental stability.

Before the Section of Urology of the 1938 session of the American Medical Association in San Francisco, published in the *Journal* for February 25th, Silver and Elliott reported their experiences in the treatment of 1,625 cases of gonorrhea in the male with sulfanilamide. With the aid of sulfanilamide the authors believe that 75 per cent. of patients with acute gonorrhea, in the male, can be cured in something like eight weeks. This is a most encouraging statement, but physicians in general to be assured of this happy result cannot hope to be so clinically fortunate unless they follow in detail the methods and procedures required. The authors had an abundance of material, the work was most carefully conducted and the patients surrounded with every possible protection. Their report brought out, however, again the important fact that sulfanilamide is not a remedy to be handled with a careless disregard of its dangers and possibilities.

It is imperative that the patient treated by this method be under careful supervision, the doctor alone should be and is responsible as to how often a patient must report, but it must be stated that unhappy results and adverse reactions many times can occur with startling suddenness. Until there is presented clinical evidence to the contrary—gonorrhea to be successfully treated demands maximum tolerance of the drug and this implies close observation of the patient. The laboratory methods required to detect early signs of trouble cannot be omitted without disaster, sooner or later, and it also must be admitted that the statement of Jones[1] of Seattle is true beyond equivocation: "Sulfanilamide, while a most efficient remedy, had multiplied the difficulties of proving the presence or absence of gonococci. . . . Sulfanilamide has multiplied the technician's work and added greater uncertainty to the value of his result."

[1] W. Ray Jones: Discussion on paper of Silver and Elliott. *Journal A. M. A.*, Vol. 112, No. 8, Page 728.

The Eighty-Seventh Annual Session

The eighty-seventh annual session of the Maine Medical Association will be held at Poland Springs, Sunday, Monday and Tuesday, June 25, 26 and 27, 1939. The central location of Poland Springs makes it the ideal spot for our annual meeting. The new management has given us reduced hotel rates with free parking. Golf can be played all day on the beautiful eighteen-hole course, for one dollar. An orchestra will be available at dinner, both for entertainment and dancing.

Through the kindness of Col. Jim Campbell, who gave us Kenneth Roberts and the famous Italian surgeon, we have an entertainment for Sunday evening, by a nationally known prestidigitator. This is actually the tops in the field of mysticism.

Monday and Tuesday mornings, the usual conferences will be held. The conferences this year, however, will be run differently, each conference lasting from 9.30 to 12.00, with a Chairman for each section. Several doctors will participate at each conference. Monday afternoon will be a Clinico-pathological Scientific session. Monday evening, we have a fine speaker from New York. Tuesday afternoon, we will have three nationally known doctors for the scientific session.

We are pleased to announce that, for the banquet on Tuesday evening, Doctor Morris Fishbein, Editor of the *Journal of the American Medical Association,* will be with us and will give us the low-down on Socialized Medicine, as dictated from Washington.

Mrs. Bunker, the wife of our active President, is planning special entertainment for the ladies, throughout the session.

For those who are visualists and do not enjoy scientific speeches, we will have a number of moving pictures on medical subjects. The scientific and drug exhibits will be better than ever.

The weather man has promised us good weather, for a change, so come and bring along the ladies for all three days. I am sure that you will all be reimbursed in knowledge and a wonderful good time.

Stephen A. Cobb,
Chairman, Scientific Committee.

Help Find Early Tuberculosis

The Maine Public Health Association, authorized representative of the National Tuberculosis Association, asks everyone to Stop, Look, and Listen!

Why must eight out of every ten patients admitted to tuberculosis sanatoria have *advanced* tuberculosis? Are the doctors wholly to blame for this? No, but who *is* going to pick up the chronic spreader of the tubercle bacillus who does not think he is sick enough to go to a doctor?

Tuberculosis is still the leading cause of death from the age of fifteen to forty-five. Why, when tuberculosis is a curable disease? Tuberculosis should be a minor cause of death. Have we not boasted that the family doctor has acted from a certain sense of responsibility, not only for his families, but also for his locality?

Let us see to it that ideologists of federal treasury care and control of the sick, in their hunt for explosive arguments, find only "duds."

Be tuberculosis-conscious. Be tuberculosis-suspicious. Thus

Help Find Early Tuberculosis

"The Women's Field Army Is Ready to March"

The Women's Field Army can report with a great deal of satisfaction that from January 23 to March 21, seventy-three Districts have been organized for complete participation in the 1939 educational and enlistment campaign. This is most encouraging, in view of the fact that almost all of this has been done by mail. It shows how great is the interest in the work of the Army all over the State, for every County is represented in the units organized.

In addition to the Districts organized for active participation, approximately thirty will be covered by a direct mail appeal or a combination of letter and personal solicitation. Of this total, twelve Districts have never participated in previous campaigns.

With the permission of the Maine Medical Association and of Dr. Edward H. Risley, Chairman of the State Advisory Board of the Women's Field Army, copies of the very fine editorial on the Army appearing in the February issue of The Journal of the Maine Medical Association were sent to all the daily newspapers and several of the weeklies with the request that it be reprinted or an editorial be based upon it. This is bringing a most gratifying result and should answer conclusively the questions sometimes asked about the attitude of the physician and the Medical Association toward the work of the Women's Field Army.

Irvin Abell, M. D., President of the American Medical Association, praises the Women's Field Army for enabling the medical profession to apply more efficiently its constantly increasing fund of medical science about cancer in a statement made public recently.

Dr. Abell's full statement follows:

"One of the chief duties of the medical profession is the acquisition and advancement of medical knowledge. The responsibility for such accumulation rests solely on the profession: Of equal importance is the dissemination of this knowledge, which, while also a responsibility of the profession, is one gloriously shared by lay organizations. To none is more credit due for unselfish effort in this direction than to the Women's Field Army of the American Society for the Control of Cancer, which, bringing to the public factual data and knowledge concerning cancer, enables the profession to apply more efficiently the constantly increasing fund of medical science concerning it. This benevolent coöperation, actuated by an altruistic impulse to help one's fellowman, saves many lives that would otherwise be lost. The instances of man's inhumanity to man lose ground and perspective in the light of this magnificent example of man's humanity to man."

Graduate Education

Commonwealth Fund Fellowships

The attention of the members of the Maine Medical Association is called to the Fellowships available through the courtesy of the Commonwealth Fund.

Information regarding these Fellowships, and application blanks may be obtained from the Division of Public Health, The Commonwealth Fund, 41 East 57th Street, New York City; Frederick T. Hill, M. D., Chairman of the Committee on Graduate Education, Waterville, Maine, or Frederick R. Carter, M. D., Secretary of the Maine Medical Association, Augusta, Maine.

A Course in Allergy

A course in allergy is open, on application, to physicians of Maine under the auspices of the Bingham Associates. A fee of $25.00 is charged for the course, which is of one week's duration, but a Fellowship fee of $50.00 is allowed and physicians taking the course may obtain board and room at the hospital for $10.00. Full information is available from Frederick T. Hill, M. D., Waterville, Maine, or Frederick R. Carter, M. D., 22 Arsenal Street, Portland, Maine.

County News and Notes

Androscoggin

The March meeting of the Androscoggin County Medical Society was held at the Auburn Y. M. C. A., Thursday, the 16th, at 8.15 P. M.

After a very short business meeting, an interesting paper on *Pyuria in Infants and Children*, was presented by Dr. Thomas A. Foster of Portland. The paper was discussed from a urologist's point of view by Dr. Roderick Huntress, also of Portland. Several cases were presented with X-rays and an interesting discussion followed.

Meeting adjourned at 10.30 P. M.

W. P. Webber, M. D., *Secretary.*

Cumberland

A meeting of the Cumberland County Medical Society was held Friday, March 3, 1939. Dinner at the Eastland Hotel at 6.30 P. M. Dr. Leon Babalian and Dr. Albert D. Foster of Portland were elected to membership. The Panel Discussion of Cardio-Vascular Diseases, Dr. E. E. Holt, Jr., Chairman, was presented.

The following cases were presented at a Clinic at the Maine General Hospital at 4.30 P. M.:

Dr. E. E. O'Donnell—Peripheral Embolism, after Pelvic Operation.

Dr. Jack Spencer—Post-operative Parotitis.

Dr. J. R. Hamel—Convulsive Seizure and Hemianesthesia.

Dr. C. C. Corson—1. Multiple Compound Fractures of Hand, with Gas Bacillus Infection. 2. Spiral Fracture of Femur, with Skeletal Fixation Applied under Novocain.

Dr. H. M. Tabachnick—Unconsciousness and Glycosuria.

Harold V. Bickmore, M. D.,
Secretary.

Kennebec

A meeting of the Kennebec County Medical Association was held at the Augusta General Hospital, Thursday, March 16, 1939.

Clinical session at 5 P. M. which was presided over by Leon D. Herring, M. D., President.

(1) Syphilitic Aortitis—W. H. McWethey, M. D.

(2) Luetic Hepatitis with Secondary Anemia—V. T. Lathbury, M. D.

(3) Fractured Skull—Thomas F. Fay, M. D.

(4) Complete Placenta Praevia—John Metzgar, M. D.

(5) Intestinal Obstruction—Samuel H. Kagan, M. D.

(6) Chronic Cholecystitis with complications—G. H. Lambert, M. D.

Dinner at 6.30 P. M., followed by a business meeting.

Minutes of the last meeting were read and approved.

Scientific Session at 7.30 P. M.

Attorney Herbert E. Locke of Augusta spoke relative to the bills introduced in the present session of the legislature which pertained to the medical profession. This talk was very interesting and stimulated a great deal of discussion.

There were 33 members and guests present.

Respectfully submitted,
Frederick R. Carter, M. D.,
Secretary.

Piscataquis

A meeting of the Piscataquis County Medical Association was held in Sangerville, February 23rd, at Dr. Stuart's office. The meeting was called to order by President Bundy. Communications from the Maine Medical Association were read. It was voted that the President appoint a committee to draw up resolutions on the death of Dr. D. L. Harden of Brownville Junction, which death took place on February 6th. President Bundy appointed Drs. Crosby, R. H. Marsh and Pritham to this committee. They retired and brought in their resolutions.

Dr. Charles D. Cromwell of the State Sanatorium at Fairfield gave a talk on Tuberculosis.

N. H. Nickerson, M. D.,
Secretary.

New Members

Cumberland

Leon Babalian, M. D., Portland.
Albert D. Foster, M. D., Portland.

Sagadahoc

Albert S. Owen, M. D., Bath.
E. M. Fuller, Jr., M. D., Bath.

Washington

H. Grubin, M. D., Lubec.

Coming Meetings

County Medical Societies

Cumberland

Cumberland County Medical Society, H. V. Bickmore, M. D., 723 Congress Street, Portland, Secretary.

There will be a meeting of the Cumberland County Medical Society on Friday, April 21st, at the Eastland Hotel at 7.00 P. M.

Speaker: Richard H. Overholt, M. D., Boston, Massachusetts.

Subject: *Some New Developments in the Management of Chest Lesions.*

This meeting will be preceded by a Clinic at the Maine General Hospital at 4.30 P. M.

Kennebec

Kennebec County Medical Association, Frederick R. Carter, Augusta, Secretary.

April 20, 1939, at the Gardiner General Hospital. Speaker: Samuel Levine, M. D., Boston. Subject: *The Ausculation of the Heart.*

May 18, 1939, at the Veterans' Administration at Togus, Maine.

Knox

Knox County Medical Association, A. J. Fuller, M. D., Pemaquid, Secretary.

The next meeting of the Knox County Medical Association will be held Tuesday, April 11th, at The Copper Kettle, Rockland, at 7.00 P. M. Speaker: Dr. Tannhauser, Boston, Massachusetts. Subject: *Vitamin Deficiencies.*

American Medical Association

American Medical Association, St. Louis, May 15-19, 1939

State Medical Associations

Connecticut State Medical Society, New Haven, May 25-26. Creighton Barker, 258 Church Street, New Haven, Connecticut, Secretary.

Maine Medical Association, Poland Springs, June 25-26-27. Frederick R. Carter, 22 Arsenal Street, Portland, Maine, Secretary.

Massachusetts Medical Society, Worcester, June 6-7-8. Alexander S. Begg, 8 Fenway, Boston, Massachusetts, Secretary.

New Hampshire Medical Society, Manchester, June 8-9. C. R. Metcalf, 5 S. State Street, Concord, New Hampshire, Secretary.

Rhode Island Medical Society, Providence, June 7-8. Guy W. Wells, 124 Waterman Street, Providence, Rhode Island, Secretary.

Vermont State Medical Society, Burlington, 1939. Benjamin F. Cook, 46 Nichols Street, Rutland, Vermont, Secretary.

Available Panel Discussions

The following panel discussions are available to County Societies and dates for any of them may be arranged by conferring direct with the Chairman of the different panels or Frederick T. Hill, M. D., The Professional Building, Waterville, Maine.

1. Pneumonia: Frederick T. Hill, M. D., Waterville, Chairman.
2. Cardio-Vascular Diseases: E. E. Holt, Jr., M. D., Portland, Chairman.
3. Fractures: Allan Woodcock, M. D., Bangor, Chairman.
4. Laboratory Methods and Their Relation to Clinical Examination: Julius Gottlieb, M. D., Lewiston, Chairman.
5. Acute Appendicitis: F. H. Jackson, M. D., Houlton, Chairman.
6. Cancer: E. H. Risley, M. D., Waterville, Chairman.
7. Surgery of the Thorax: George E. Young, M. D., Skowhegan, Chairman.

Necrologies

Orville Leon Hanlon, M. D., 1875-1938

The death on December 10, 1938, of Doctor Orville Leon Hanlon, 63, of Mexico, Maine, marked the passing of one of the outstanding physicians and surgeons of Oxford County.

Doctor Hanlon was born March 28, 1875, in North Andover, Massachusetts, the son of Peter Francis and Annie P. Worthington Hanlon.

He received his preliminary education in Berlin, New Hampshire. After graduating from the High School, he entered Bowdoin College and received his A. B. degree in 1897 and his M. D. degree in 1901. Doctor Hanlon entered the practice of medicine in Ridlonville (Mexico), Maine, and continued there until his death from Coronary Thrombosis. He enjoyed a large practice and was on the Surgical Staff of the Rumford Community Hospital. He was a member and past president of the Oxford County Medical Society, a member of the Maine Medical Association and the American Medical Association. He was a member of the Walton Lodge, Knights of Pythias, of Mexico, and of the Rumford Lodge of Elks, and a member of the School Board for a number of years.

He is survived by his widow, who was Miss Mildred B. Woodwaid of Ridlonville, his mother, who resides in Ridlonville, a son, Dr. Francis Hanlon of Portland, and two grandsons, Peter Francis Hanlon and Nicholas Richard Hanlon of Portland.

Frank Washington Tarbell, M. D., 1879-1939

Frank W. Tarbell, M. D., for many years a practitioner at Smyrna Mills, died suddenly at his home early Saturday, February 25th. He was born in Dyer Brook, July 31, 1879. With the exception of a short time in Massachusetts had always practiced in Smyrna Mills. Dr. Tarbell for the past few years had not been in the best of health but had carried on an extensive country practice and the day before his death went about his calls as usual.

He was a former member of the Aroostook County Medical Society, had served on several committees and also as its President, but of late years had not been a member. He is survived by his widow and one daughter.

Daniel Nash Woodman, M. D., 1861-1938

Doctor Daniel Nash Woodman, 77, of North Haven, died at Portland, November 26, 1938. He was born at Sweden, Maine, March 31, 1861, and graduated from the College of Physicians and Surgeons, at Baltimore, Maryland, in 1893. Doctor Woodman practiced in Yarmouth for thirty-five years and in North Haven for eight years. He was a member of the Cumberland County Medical Society.

Notices

Teaching Clinic
Central Maine General Hospital
Lewiston, Maine

April 28, 1939 (Friday)

9.30 A. M.-12.00 M. Clinic to be conducted by Dr. John Fraser.

Demonstrations and Discussions—

1. Chronic Pelvic Infection.
2. Carcinoma of Cervix.
3. Idiopathic Uterine Bleeding.

3.00 P. M.-5.00 P. M. Ward Walks and Round Table Discussions on Obstetrical and Gynecological Problems.

8.00 P. M. "The Treatment of Hemorrhage in Late Pregnancy" by Dr. John Fraser, Professor of Obstetrics and Gynecology, McGill University Medical School.

TEACHING CLINIC COMMITTEE,
Central Maine General Hospital.

Gerrish Library Anniversary Clinic
Central Maine General Hospital
Lewiston, Maine

May 19, 1939

Evening Speaker: Dr. Jonathan C. Meakins, Professor of Medicine, McGill University Medical School.

Paper: "Doctors and Libraries."

Full Clinic Day.

TEACHING CLINIC COMMITTEE,
Central Maine General Hospital.

1939 State May Day Committee

The State May Day Committee for 1939 held its first meeting at Augusta, March 22nd, to formulate plans for the present year. The Committee as ap-

pointed by the State Chairman, Robert E. Jewett, M. D., Director of the Division of Maternal and Child Health, is as follows:

Thomas A. Foster, M. D., Portland

Mr. Edward E. Roderick, Department of Education, Augusta

Mrs. Ralph Ingraham, Augusta

Mrs. Theresa Anderson, Augusta

Miss Florence Jenkins, Department of Education, Augusta

Miss Edith Soule, Division of Public Health Nursing, Augusta

Mr. C. Harry Edwards, Department of Education, Augusta

Bureau of Health Services for Crippled Children 1939

Clinic Schedule

Rumford: *Rumford Community Hospital*—1.00 P. M. to 3.00 P. M., Wednesday, May 24th.

Machias: *Washington State Normal School*—1.00 P. M. to 3.00 P. M., Wednesday, April 26th.

Lewiston: *Central Maine General Hospital*—9.00 A. M. to 11 A. M., Saturday, April 29th, May 27, June 24th.

Bangor: *Eastern Maine General Hospital*—1.00 P. M. to 3.00 P. M., Thursday, May 4th, June 1st, June 29th.

Portland: *Children's Hospital*—9.00 A. M. to 11.00 A. M., 1.00 P. M. to 3.00 P. M., Monday, April 10th, May 8th, June 12th.

Presque Isle: *Northern Maine Sanitorium*—9.00 A. M. to 11.00 A. M., 1.00 P. M. to 3.00 P. M., Tuesday, May 16th.

Rockland: *Knox County Hospital*—1.30 P. M. to 3.00 P. M., Thursday, June 15th.

Waterville: *Thayer Hospital*—1.30 P. M. to 3.00 P. M., Wednesday, May 31st.

NOTE: No Clinic appointments can be made for patients during the last five days prior to the Clinic except for cases who are referred in directly by physicians.

American Association of Industrial Physicians and Surgeons

The 24th annual meeting of the American Association of Industrial Physicians and Surgeons with the American Conference on Occupational Diseases and Industrial Hygiene will be held at the Hotel Statler, Cleveland, Ohio, June 5, 6, 7 and 8, 1939.

Information regarding hotel accommodations, etc., may be obtained from A. G. Park, Convention Manager, 540 North Michigan Avenue, Chicago.

American Association of Obstetricians

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons announces that the annual Foundation Prize for this year will be $100.00. Those eligible include only (1) interns, residents, or graduate students in Obstetrics, Gynecology and Abdominal Surgery, and (2) physicians (M. D. degree) who are actually practicing or teaching Obstetrics, Gynecology or Abdominal Surgery.

Competing manuscripts must (1) be presented in *triplicate* under a nom-de-plume to the Secretary of the Association before June 1st, (2) be limited to 5,000 words and such illustrations as are necessary for a clear exposition of the thesis, and (3) be typewritten (double-spaced) on one side of the sheets, with ample margins.

The successful thesis must be presented at the next annual (September) meeting of the Association, without expense to the Association and in conformity with its regulations.

For further details, address Dr. James R. Bloss, Secretary, 418 11th Street, Huntington, W. Va.

Annual "Radium Number" Mississippi Valley Medical Journal

The March issue is the twelfth annual "Radium Number" of the Mississippi Valley Medical Journal (Incorporating the Radiologic Review), published at Quincy, Illinois. This contains ten original articles. written especially for this issue, the most of which are contributed by well-known American radiologists.

Pohle of the University of Wisconsin, has an interesting article on angiofibroma and gives a case report showing an excellent result with interstitial radium. Jorstad of St. Louis, shows the effectiveness of interstitial radiation in certain locations. Levin of New York City, shows the importance of effective radium therapy in prostatic and bladder cancer. Swanberg of Quincy, has a valuable contribution entitled "What Radiation Technic Gives the Best Clinical Results in Uterine Cervical Cancer?", which is a statistical study of the five year end-results in 3,759 treated patients. There are a number of other interesting articles, including an editorial on "The Radium Rental Controversy"; in the latter, the editor points out the evils of the recently inaugurated long time, unsupervised, radium "leasing plan" and compares it with the more conservative, short time, supervised, radium "rental plan" which has been in use for the last quarter of a century.

American Physicians' Art Association

The American Physicians' Art Association composed of members in the United States, Canada, and Hawaii, will hold its second Art Exhibit in the City Art Museum of St. Louis, May 14-20, 1939, during the annual session of the American Medical Association. Art pieces will be accepted for this art show in the following classifications: (1) oils both (a) portrait and (b) landscape, (2) water colors, (3) sculpture, (4) photographic art, (5) etchings, (6) ceramics, (7) pastels, (8) charcoal drawings, (9) book-binding, (10) wood carving, (11) metal work (jewelry). Practically all pieces sent in will be accepted. There will be over 60 valuable prize awards. For details of membership in this Association and rules of the Exhibit, kindly write to Max Thorek, M. D., Secretary, 850 Irving Park Blvd., Chicago, Illinois, or F. H. Redewill, M. D., President, 521-536 Flood Bldg., San Francisco, California.

Book Reviews

"The Biology of Human Conflict—An Anatomy of Behavior Individual and Social"

By Trigant Burrow, M. D., Ph. D., Scientific Director, The Lifwynn Foundation, New York City.

Published by The Macmillan Company, 60 Fifth Avenue, New York, 1937. Price, $3.50.

Dr. Burrow has set for himself a most difficult task and has placed obstacles, which at the present state of human knowledge appear almost insurmountable, upon the road which the medical profession must travel in order to reach their ultimate goal, a more perfect human society. More than fifteen years ago Dr. Burrow set out to discover if possible the cause or causes for mankind's most disastrously destructive form of insanity, that form of insanity which displays its kaleidoscopic symptomatology daily for our senses to perceive, elaborate and act upon, human fears and human hates as they are actively expressed in our everyday behavior. The fears and hates of mankind, directed not only by man against man, man against woman, woman against man, woman against woman, etc., etc., but directed also against the creations of man's imagination which in their turn initiate new forms of fears and hates, are only part of a long chain of causes for human conflicts and maladjustments which often impel man to actions quite contrary to his natural human inclinations and often contrary to his best interests. When the action of these disharmonious forces produces impressions which lead to irreversible memory constructs and action currents, we suffer from progressive but disintegrative disturbance of peace of mind and feeling of human kindness. This is true whether we are afflicted as an individual or as a member of a smaller or larger organized group of similarly situated individuals.

With truly scientific enthusiasm and personally disinterested determination the author works persistently in search of and hope for finding the causes and possible cures for the many forms of pathologic biologic adjustments which torment "normal" modern mankind. He labors patiently in the service of truth. From time to time he has published the results of his investigations in book form as well as in several national and international journals.

The present volume appears to be a sort of summary of the work so far accomplished and points the way which we must travel if we hope to attain a more profound insight into the nature of the basic foundations of human conflicts and the various forms of maladjustment and associated defense reactions which result therefrom. Some helpful suggestions are offered which may lead to the possible discovery of practicable dependable remedial agencies with which to successfully meet the various critical situations as they arise. The sincerity of the author and his conviction that he is in possession of truths founded upon scientific experiment and experience is excellently expressed in the following quotation, taken from the volume under review: "If medicine is adequately to appraise the condition of division and conflict existing within the community under its guise of 'normality,' we shall have to adopt a fundamentally altered attitude toward the problem of mental disease. We shall have to apply to these manifestations the same qualitative methods of study that have characterized medical research in other fields.

"The absence of peace, of order within the processes of man is world-wide. But this lack of harmony is not resident within the sphere of man's ideas. It is not to be found in his political dis-

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sensions, his religious disparities, his social and economic conflicts. Neither is the seat of his disorder to be found in what has been described as his neurosis, crime or insanity. These manifestations are but the external signs. The real disorder consists of a lack of coördination and peace that is primary and internal to man. The disorders of behavior we have called mental are to be found in organic processes that are as clearly demonstrable objectively, qualitatively, as the disordered processes responsible for other diseases occurring within the organism.

"Man is undoubtedly ill-adjusted and unhappy. There is not alone the ill health of the individual but of nations, of the world at large. Philosophy, metaphysics, academic education, politics or economics will not avail. The need is definitely a physiological one. In the disturbance of order and harmony within man's personal and social processes we are confronted with basic, underlying causations internal to the organism. We are confronted with a fundamental disturbance in the internal motivations of man as a species. The investigations of individuals and of groups, as conducted by the scientific staff of the Lifwynn Foundation, have made evident that these internal disharmonies in behavior-motivation are traceable to a conflict between definite neuro-muscular patterns of reaction. They have made it evident that as these patterns are physiological and internal to the organism they may become perceptible and amendable to remedial measures only in the degree in which medicine adopts an internal technique of procedure that will give to these processes clear physiological definition and enable us to deal with them in their immediate underlying objectivity. When disorders of human behavior, individual and social, have been stripped of their purely ideological, metaphysical implications and we have assumed toward them the same scientific attitude we have adopted toward clinical disease-process as it occurs in this or that specific organ or tissue of the individual—only then will medicine have fulfilled the full scope of its obligation to deal objectively with disordered human processes."

"Syphilis"

Edited by Forest Ray Moulton. The Science Press, Lancaster, Pa., 1938.

This is the third medical symposium of the American Association for the Advancement of Science. Previously published symposia were "The Cancer Problem" (1937) and "Tuberculosis and Leprosy" (1938). The next one to be published in 1939 is "Mental Health." Each symposium is organized by the secretary of the section in co-operation with a committee of eminent experts on the subject to be discussed.

Syphilis is considered to be the most serious public health problem in the United States. Until about thirty years ago not even the cause of this disease was known, much less its cure. Now the various co-authors of this symposium show us that syphilis, like many other diseases, has many relatives, the most common being Yawes and Bejel. They also show us by so-called documentary evidence that the notion or belief that syphilis was contracted by some of Columbus' sailors while in Haiti, transported to Barcelona and transmitted with wildfire rapidity to all parts of Europe within a very few years with the result that thousands of sufferers died during an epidemic, may be erroneous.

There are many other illuminating remarks made by everyone of the thirty contributors, in regard to diagnosis, treatment, control and prognosis of this disease complex, commonly known by the name syphilis. It is worth while scientific medical literature plainly stated.

"Surgical Treatment of Hand and Forearm Infections"

By A. C. J. Brickel, A. B., M. D., Department of Anatomy and Surgery, Western Reserve University, with 166 Text Illustrations and 35 plates, including 10 in color. Published by the C. V. Mosby Co., St. Louis, 1939. Price, $7.50.

The human hand plays a highly significant part in industrial medicine. Minor injuries to a finger often lead to prolonged incapacitation of the hand for purposes of gainful employment. Even when correctly treated by the attending physicians, unwholesome criticism is often voiced. Dr. Brickel has laboriously tried to discover possible reasons for troublesome complications which often follow apparently appropriate and successful initial thera-

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peutic measures. With the help of diligent laboratory and X-ray experimentation, he has developed a form of treatment which, if faithfully carried out, promises more positive results than were possible by the trial and error method of former years. Very valuable suggestions are presented concerning the use of local anesthetics, the rules of probability for the spread of infections, as well as definite instructions for conservative efficient surgical and medical care with a view toward the attainment of best possible utilitarian results with the least possible loss of time from unemployment.

"The Complete Guide to Bust Culture"

By A. F. Niemoller, A. B., M. A., B. S., with a Foreword by Edward Podolsky, M. D. Published by the Harvest House, New York, 1939. Price, $3.50.

It is claimed that this is the first and only book in any language written for the purpose of presenting in non-technical language methods for the care of what must hereafter be called the bust. According to the author, the terms breast, bosom and bust are frequently employed interchangeably, which is very wrong. "Properly speaking, breast refers to the mammary glands, of which a woman normally has two, and takes account of it as a functioning organ as well as a shaped appendage of the body. Bosom, on the other hand, connotes the shape and substance of the two breasts taken as a unit portion of the female body and concerns largely only the exterior aspects. But bust is the broadest of them all; it refers not only to the two breasts considered together in the sense of bosom, but also to the contour of their blending with the sweep of the chest above and the lines of the body immediately below."

In twenty-three chapters the lay reader is told what she can do or have done for the purpose of improving her bust contour. "All lotions and devices and most of the popularized 'treatments' are wholly useless." Physical exercise, appropriately selected, well fitted brassieres and skillfully performed corrective plastic surgery are discussed at length.

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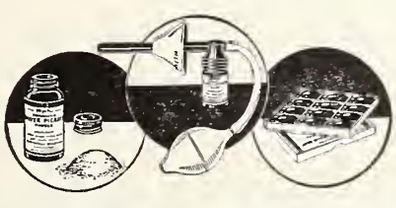

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Cutaneous Burns

By Gordon N. Johnson, M. D., Portland, Maine

These injuries are so common as to constitute a real problem in therapy. One finds a multiplicity of treatment, some good, some not so good. It is a source of annoyance for one being called to treat a burn to find some form of grease applied.

In no condition in surgery is there more need for care in the details of treatment or more urgent demand for careful nursing. The surgeon should consider in his plan of therapy not only the burned area, but the treatment of the individual as well.

Classification:

1. Thermal.
   Fire, boiling liquids.
2. Electrical.
3. Chemical.

Local Pathology:

"A first degree burn clinically is an erythema or reddening of the skin without evident damage. There may be a desquamation of superficial epithelium in a day or two, followed by subsidence of hyperemia."

"A burn of the second degree is accompanied by reddening and blisters, destroying all the epidermis but that dipping into the hair-follicles."

"The third degree burn involves the tissue beneath the skin down to and even including bone."

Burns in general are characterized by a terrific over-response and local congestion and engorgement far beyond that seen following other traumata producing the same amount of tissue damage. The tremendous edema, exudation and infiltration of the tissues in and about the burned area is responsible for the extremely painful nature of burns.

In third degree burns of any depth the pathological picture is serious. Surrounding the area of necrotic skin and tissue beneath there will be a zone of intense inflammatory reaction, fading out gradually into the relatively normal tissue of the uninjured portion. This is a zone of marked swelling, redness, heat, pain and tenderness. The dead tissue is often white at first; later, as drying sets in, it becomes darker in color, until it is finally seen as a black slough in the process of separation. These appearances are often altered by the fact that blisters may cover the surface of what really is a severe burn. The

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intense inflammatory zone represents a line of demarcation.

General Pathology:

Several theories have been advanced to account for death occurring in from six to ten days of symptoms suggestive of toxemia. Robertson and Boyd burned the skin of young rabbits. In one series the burned skin was removed within eight hours and grafted to an unburned rabbit; the skin of the latter being grafted to the former.

Toxemia developed in the rabbits receiving the burned transplants, but none of the others were affected. If, however, the transplants were made after eight hours both series of rabbits exhibited evidences of toxemia. They further showed that the serum of burned children, when injected into rabbits was innocuous, but the injection of citrated whole blood caused typical toxemia.

There is marked concentration of the blood ranging up to 200% of normal; the sodium chloride content shows an inverse ratio to the concentration by the haemoglobin.

Fever is a constant symptom and remains for a week or ten days and then subsides. If no subsidence or the temperature is spiking it is an ominous sign. The extensive burns reveal shock with its classical signs of pallor, sweating, wide-awake consciousness, rapid shallow respiration, a feeble rapid pulse and low blood pressure.

Pain may be severe, at other times complained of little, if at all. Vomiting may be present. Ulcers of the stomach or other parts of the gastro-intestinal tract are mentioned in the literature, Curling first reporting such cases in 1842. Since then few reports of such have been forthcoming; though Weiskoten and Bardeen have reported numerous small ulcers of the small intestine in their studies. Focal necrosis and hemorrhage have been observed in the suprarenals.

Immediate Treatment:

As soon as the patient is seen morphia up to physiological affect should be given immediately, the clothing should be carefully removed, cut away if adherent in any part. If in shock, treat the shock with infusions of isotonic saline and 5% glucose. Then the burned area is carefully debrided using sterile forceps and scissors. This done under anesthesia. The area then is scrubbed *gently* with soap and water followed by ether.

As soon as the necrotic debris is removed apply a freshly-made-up 5% solution of tannic acid. This may be sprayed on or applied with sterile gauze. (A 5% solution can roughly be prepared by 5 teaspoonsful of Tannic Acid powder added to a glass of water.) In ten minutes follow this with a 10% solution of Silver Nitrate. Immediately there is eschar formation and the split nucleo-proteins have been precipitated. The eschar is firm and leathery and no dressing need be applied. The patient is given a prophylactic dose of antitetanic serum and gas serum, also scarlet fever antitoxin.

When in bed cradle with lights is instituted and fluids forced. Because of the ease and quickness with which the tannic acid silver nitrate procedure can be instituted it is a time-saving and patient-saving devise. In the place of this, 1% aqueous solution of gentian-violet may be applied. The great tendency has been to apply too many applications. Enough only to insure eschar formation should be used.

As the epithelium begins to grow from the islands the eschar tends to raise and separate, to curl at the edges. This should be trimmed with a pair of sharp scissors. As the granulations become healthy the eschar likewise tends to separate. It is now that grafting should be done, not waiting for deep cicatrization to take place with resulting non-takes of the grafts. The area, if slightly septic, may be readily cleaned by the use of 1-5000 neutral solution of acriflavine applied as wet dressings. Picric acid should not be used in extensive areas because of the possible toxic result of the phenol radical; chlorinated dressings macerate the tender new epithelium; Boric likewise has similar action.

If the burned area becomes septic the eschar will be raised over the purulent section. Remove and start 1-5000 acriflavine wet dressings. The dressings may be changed once in twenty-four hours.

Small transfusions, a liberal diet, high in vitamins, particularly vitamin C and vitamin

A, all aid to the rapid recovery of the patient. Chlorides in the form of infusion, or sodium chloride in capsules, 5 grs. three times daily for several days will prevent depletion of the blood chloride values. If pinch grafts have been used and seem to be doing poorly place the patient in a tub of warm water and gently with the finger rub the grafted area. Debris is removed and a singular stimulation of epithelium is noted. If prior to the grafting the granulation seems sickly a wet dressing of amfetin brings about excellent results.

When the eschar has been removed a delicate pink epithelialization is noted. To prevent fissuring gently massaging with olive oil two or three times a day gives very pleasing results.

In the event burns have occurred over joints these should be placed in extension and kept there until active mobilization is possible. Many unsightly and crippling deformities due to retractions of cicatrices could be prevented if this simple procedure were enforced.

Chemical burns are best treated by the continued application of water to prevent the agent from penetrating deeper.

Electrical burns penetrate much deeper than is at first apparent. Debridement with subsequent grafting prevents the toxic manifestation of absorption of the split muscle proteins.

Conclusions:

1. Burns classified as to etiology and severity.
2. Pathology—local and general.
3. Treat the patient for shock, anemia and depletion of blood chlorides.
4. Local treatment of debridement, thorough cleansing, applications of 5% solution of tannic acid followed in ten minutes by 10% solution of Silver Nitrate.
5. Early grafting to prevent cicatrix formation.
6. Extension of joints where burns involve these.

References:

Davidson, E. C.: Tannic Acid in Treatment of Burns. *S. G.* 10, 41:202, 1925.

Weiskoten, H. G.: Histopathology of Superficial Burns. *J. A. M. A.* 72; 259, 1919.

Homans, John: A Test Book of Surgery, 107, 1932.

Murray, C. R.: The Treatment of Injury, Vol. 1, 52, 1931.

Bancroft, F. W.: Nelson's Loose-Leaf Surgery, Chapter VIII, Vol. I.

Appendicitis in Children

Too many children die from the complications of appendicitis. . . . The obvious solution to this situation is early diagnosis and early operation, which limits the problem to one of acute appendicitis without complications. In this stage of the disease the mortality is negligible. . . . The unwise use of cathartics in the presence of abdominal pain is an important factor in causing peritonitis to result from appendicitis and in keeping up the high mortality. . . . Delayed operation or the Ochsner treatment is probably less effective in the child than in the adult, but is occasionally desirable, even in the child. Its employment should be limited to surgeons of experience. When incorrectly used and misapplied, it is harmful, not helpful.—William E. Ladd, M. D., *The New England Journal of Medicine,* Vol. 219, No. 10, pp. 329-333, September 8, 1938.

Transfusion Anuria

Doctor E. Granville Crabtree of 99 Commonwealth Avenue, Boston, Massachusetts, is attempting to assemble sufficient pathological material on the kidney in misfit transfusion anuria in pregnancy to enable him to place this subject in a book on urinary diseases in pregnancy. Because of the frequent need for transfusion in obstetrics there are cases of this nature in considerable number but they are widely scattered. Dr. Crabtree will appreciate notes, pathology reports and pathological slides which you may be able to contribute and will give proper credit for material used in publication.

Acute Hemorrhagic Encephalitis

Report of a Case

By H. I. Goldman, M. D., Freeport, Maine

Acute hemorrhagic encephalitis of the Strumpell type usually occurs in infancy and early childhood, and occasionally in adults. This type is diffuse, involving all of the structures of the brain. It follows an acute general infection, such as influenza, measles, or scarlet fever.

The following is a case report of an adult with one attack relieved, but a subsequent attack proving fatal. We were fortunate in obtaining permission for a post mortem, which, although limited to the head, proved valuable.

Case Report

F. M. White male. Age 69. Retired school teacher.

Chief Complaint: Severe cough, temperature, stupor.

Present Illness: Two weeks ago a physician saw the patient and made a diagnosis of "grippe." The patient apparently recovered from this infection in five days. Eight days later the patient began to show periods of apparent stupor interspersed with periods of delirium reaching the point where force would be necessary to put the patient to bed. The next morning when he failed to improve, a physician was called.

Family History: Married twice. First wife died of cancer. Father died of tuberculosis; mother of cerebral hemorrhage.

Past History: Usual childhood diseases. Pneumonia 17 years ago. Grippe 5 years ago. Up to two years ago the patient was employed in the department of education in another state in an executive capacity. He had been a teacher since his graduation and had been considered as having a more than average intellect by impartial observers. Two years ago both the patient and his wife noticed that his mental capacity and personality were changing for the worse. A competent neurologist was consulted, who made a diagnosis of early cerebral arteriosclerosis. The patient resigned his job and retired. Since retirement his wife noticed that he had become slovenly about his heretofore immaculate appearance, lost his powers of concentration on any one given subject, and was disoriented in his speech.

All of this history was obtained from his wife. At no time up to the death of the patient were we able to get any story from the patient himself.

Physical Examination: Showed a well-developed and fairly well-nourished white male, lying in bed, moaning softly, and hard to arouse. T. 103.6 F. rectal. Pulse 110—full and bounding. Resp. 30—shallow.

Head: No abnormalities or evidence of injuries.

Eyes: Pupils equal but react very sluggishly to light. Ophthalmoscopic examination showed the fundic vessels to be very tortuous and full. The margins of the optic discs were poorly defined. There were no exudates or hemorrhages visible in the fundi.

Ears, Nose, Throat: Essentially negative.

Neck: No palpable glands. Thyroid not felt.

Chest: Dullness over both bases with decreased tactile fremitus and diminished bronchial breath sounds. Numerous moist rales were heard over both bases. Heart sounds were regular with no murmurs or other abnormalities.

Abdomen: Essentially negative.

Neurological: Neck rigid. Arms spastic and no reflexes obtainable. Knee jerks slight to absent on both sides. Bilateral ankle klonus, more so on the left. Negative Babinski. Ankle jerks, abdominals, cremasteric reflexes absent.

A clinical diagnosis of either brain abscess or encephalitis was made and the patient was hospitalized at the State Street Hospital, Portland.

Course at Hospital: On admission an immediate lumbar puncture was done. The fluid was under increased pressure; cell count four—all lymphocytes. Culture of the

fluid showed an isolated Gram positive diplococcus, which morphologically appeared as pneumococci but was not recovered on transplantation to solid media. Globulin was negative (Pandy); sugar 90 mg.; chlorides 725 mg. Gold sol and Kahn were negative. R. B. C. 4,800,000; W. B. C. 43,100; Hb. 85% (Dare). Urine showed a slight trace of albumen, orange-colored test (Benedict) for sugar, and a few hyaline casts. X-ray of the chest revealed no pathology.

A neurologist was had in consultation and a diagnosis of encephalitis, probably hemorrhagic in type, was made. No importance was attached to the urinary sugar nor to a later blood sugar of 287 mg., it being felt that these phenomena were related to the brain pathology and not to a true diabetes. (The urine and blood sugar subsequently returned to normal.)

On admission the temperature was 103.6 F. rectal. The next day it rose to 104.6 and the patient appeared moribund. Hypodermoclyses of normal saline, intravenous glucose and insulin subcutaneously were started. Prontosil was given intramuscularly in 5 cc. doses every four hours. The next day the temperature was 100.0 F. and except for the following three days when it rose to 101.0, did not go above that point. Daily lumbar puncture was done and discontinued as the fluid remained consistently negative. W. B. C. gradually dropped to 10,050. The patient was discharged home in four weeks to convalesce. At the time he was discharged he was still disoriented, staggered, and had a nystagmus to the left. His wife stated that his disorientation was slightly improved, if anything, as compared to his condition prior to the onset of the present illness.

Interval History: The patient's condition remained practically unchanged for approximately nine months, two of which we had him under direct observation.

Ten days before we saw him again he developed what was diagnosed as a mild upper respiratory infection, with hoarseness, nasal discharge, cough, and temperature. After that his wife noticed that when he tried to stand his body tilted to the right and he had difficulty in standing without assistance. The temperature varied from normal to 101.0 F. When no improvement was noted I was asked to see him again and made the following physical findings.

Physical Examination: The patient was sitting in a chair, fully dressed, showing marked chorieform movements of both upper and lower limbs, apparently partially comatose.

Eyes: Pupils were contracted with little or no reaction to light. Ophthalmoscopic examination showed bilateral choked discs, no exudates or hemorrhage. Nystagmus to the left.

Heart, Lungs, Abdomen: Essentially negative.

Neurological: Neck stiff, bilateral Babinski and ankle klonus. Due to condition no conclusive or adequate tests for cerebellar function could be made.

A diagnosis of an exacerbation of a chronic encephalitis was made and the patient hospitalized.

Course at Hospital: On admission lumbar puncture was done. The fluid was clear, under increased pressure, cell count 3, globulin slightly positive (Pandy). Urine was negative, W. B. C. 20,800.

Twelve hours after admission the temperature rose from normal to 103.2 F. (R.), pulse 110, respiration 18. At that time intrathecal prontylin solution prepared according to the specifications of the Winthrop Chemical Co.[1] was instituted. Prontosil in 5 cc. doses was injected intramuscularly at the same time. During the next twelve hours the clinical condition appeared very much improved. Then the temperature rose to 105.0 F. In spite of repeated lumbar punctures, medications, and supportive treatment, intracranial pressure gradually increased, the respiratory center became affected and the patient died 72 hours after admission.

The spinal fluid became xanthochromic, with a large fibrin web, which formed within a few minutes. The cell count varied from 770 to 1,500, and before death was 5,700—mostly band form polymorphs. It is my opinion that this change in character of the spinal fluid was due in part to chemical irritation from the intrathecal prontylin.

Necropsy: Post-mortem examination was done two hours after death and limited to the head.

Body is that of a well-developed, fairly well-nourished, white male, apparently 70 years of age.

Head was opened by an incision behind the ears, carried over the scalp. The scalp was reflected, the calvarium sawed through and removed. The dura was thickened and densely adherent. About 100 cc. of yellowish, slightly cloudy fluid escaped when the dura was incised.

Surface of brain is markedly swollen and tense; the vessels markedly injected.

Cerebral hemispheres were opened. The left lateral ventricle was found slightly larger than the right. The third ventricle was somewhat distended. On section the tissue of the right hemisphere is apparently normal; the left shows a replacement by a yellowish, white material, grossly taken to be gliomatous tissue.

The convolutions ranged from flattened to obliterated. Section of the cerebellum showed a similar picture. Section of the medulla was grossly normal.

Diagnosis: (1) Meningitis.
(2) Cerebral edema.
(3) Encephalitis.
(4) ? Atrophy of left side of brain.
(5) ? Acute left internal hydrocephalus.

Neuro-pathological Impressions: Over the surface were observed several small areas of thickened arachnoid and apparently some trapped white substance underneath. Question of pus. The whole of the arachnoid was definitely more dense than one would normally expect.

There were many pipe-stem vessels. Sections cross and longitudinally showed in the cut surface what looked like an increase in the amount of cut vessel ends, and probably free blood throughout the whole brain substance. This seemed about equal throughout the brain, possibly greater in the basal ganglia. No gross evidence of tumor found. No abscess collection.

Microscopic Report: Edema and neutrophilic infiltration of the meninges. (No report received on the pieces of brain tissue sent.)

Diagnosis: Meningitis (acute).

Footnote

[1] The Winthrop Co. advised using the method reported by Schwentker, Gelman and Long—*Journ. A. M. A.*, 108:1407, April 24, 1937.

Prontylin (powder form) is used. The required amount of 0.7 saline solution is first boiled for 2 minutes; when the solution cools to 90. C. there is added 0.8 gm. of Prontylin for each 100 cc. of saline solution. The hot solution is agitated to facilitate dissolving of the powder and cooled to 37. C. From 10 to 30 cc. may be injected intrathecally, but usually 5 to 10 cc. less than is taken out at puncture.

Available Panel Discussion

The following panel discussions are available to County Societies and dates for any of them may be arranged by conferring direct with the Chairman of the different panels or Frederick T. Hill, M. D., The Professional Building, Waterville, Maine.

1. Pneumonia: Frederick T. Hill, M. D., Waterville, Chairman.
2. Cardio-Vascular Diseases: E. E. Holt, Jr., M. D., Portland, Chairman.
3. Fractures: Allan Woodcock, M. D., Bangor, Chairman.
4. Laboratory Methods and Their Relation to Clinical Examination: Julius Gottlieb, M. D., Lewiston, Chairman.
5. Acute Appendicitis: F. H. Jackson, M. D., Houlton, Chairman.
6. Cancer: E. H. Risley, M. D., Waterville, Chairman.
7. Surgery of the Thorax: George E. Young, M. D., Skowhegan, Chairman.

Ragweed Survey in Maine for 1938

By Charles B. Sylvester, M. D., Portland, Maine

The survey of ragweed pollen in Maine was repeated in 1938 at one station, and four new receiving stations were added.

Owing to the surprisingly low 1937 count at Presque Isle, we were eager to check up on Aroostook County, and Houlton was selected. The result confirms the accuracy of the 1937 count, and establishes the freedom of Aroostook County from ragweed. There is a present discussion of the ragweed pollen incidence in New Brunswick and the provinces, in which comparison with our work in Aroostook County is being made by Doctor Vander Veer of New York.

A survey of Rockland was completed in an effort to tabulate the air content in the Penobscot Bay area. This appears to confirm the findings of 1937. With the prevailing westerly winds, Rockland might have a higher pollen count than the coast east of Penobscot Bay. It will be noted that the index for 1938 agrees with the index for Southport in 1937.

A survey of Rangeley Lakes was promised for this year. As a seasonal count had been established at Upper Dam five years ago, we were interested in the comparison after years of increased seasonal tourist travel and possible lessening of forested barriers. Whatever reason one pleases to assign, an increased ragweed pollen air content was maintained for the season from August 10 to September 28 at Oquossoc.

The field service of the State Bureau of Health also established a reception at the fire station on Speckle Mountain, on the Maine border to the northwest of Bethel, representing the area of mountainous extension from the White Mountains. The pollen count, as might be expected, was low.

The survey was repeated at Poland Spring, with the reception shelter placed at a lower level and less influenced by higher atmospheric wind currents. The seasonal index was considerably lower than the year before, and there was no single day's count so high as last year. There was a notable increase of pollen on September 21st, the day of the hurricane, and there was a less increase at Rockland. Apparently the White Mountains split the hurricane, the eastern portion being deflected sharply toward the center of Maine, where it gradually dissipated. Therefore, the pollen receiving stations at Speckle Mountain and Oquossoc were protected by the White Mountains range. This pollen deposit finding agrees with the timber destruction path in North Cumberland and Oxford Counties, and emphasizes the importance of the White Mountains as storm barriers.

Station	*Number of Hayfever Days*	*Highest Count for One Day*	*Total Count*	*Ragweed Index*
Houlton	1	27	57	1
Rockland	5	62	526	8
Speckle Mountain	1	33	214	2
Rangeley	6	98	418	9
Poland Spring	6	57	475	9

The technic of reception and slide preparation, exchange of slides, and laboratory counting was identical with that of last year. The Bureau of Health furnished supplies and took complete care of providing reception shelters and collecting all slides. The Bureau's chief and field officers manifested a live interest. Hearing that I had denied the presence of giant ragweed in Maine, Dr. Mitchell of the 2nd district brought "coals to Newcastle" by delivering to me a freshly-pulled specimen of matured giant ragweed from a vacant lot within the Portland city limits.

Ragweed air pollution is an *increasing danger to the allergic inhabitants of the state, and a menace to the tourist travel business. We reaffirm our conviction that ragweed can be destroyed and should be destroyed in Maine. All the splendid public spirit of garden clubs, service clubs, and village improvement associations should be co-ordinated, and should lead up to a state-wide elimination of this pest. This large-scale program could be proportionately planned at less expense.*

Continued on page 101

The President's Page

To the Members of the Maine Medical Association:

Now that belated signs of spring are in the air and our long-drawn-out session at the Legislature is about to close, our thoughts naturally are drifting toward Poland Springs, where our Annual Convention will be held on June 25th, 26th and 27th.

There is every indication that this will be a very happy and instructive occasion.

I have visited the Poland Spring House, accompanied by our secretary, Dr. Carter, and have learned to our own satisfaction that the management is willing to coöperate in every way with our committees to make this a most successful event.

The commercial exhibits, social functions, conferences, and business and scientific sessions will be held under one roof, which is a far different arrangement than has been customary in the past.

Under the direction of Dr. Stephen Cobb, our efficient Chairman of the program committee, every minute detail has been considered. The program in brief will be published in the May issue of our JOURNAL, and the complete program in the June issue.

These things all bring to our minds the fact that our Calendar Year is drawing to a close, for which many of us will be very thankful.

Our Society has been confronted with many serious problems which have demanded much time and effort, but fortunately there have been equally as many pleasant occasions; therefore, let us all get together at Poland Springs in June and work for the good of our Society and make this a gala time, long to be remembered in the history of the Maine Medical Association.

WILLARD H. BUNKER, M. D.,
President, Maine Medical Association.

Editorial

Concerning the Status of Certain Hospital Physicians

If the following statement is advanced as one of fact it might be interesting, perhaps profitable, to enquire as to the why of such an implication. According to Elton (1), "The American Hospital Association feels that the services of radiologists, physical therapeutists, anesthetists, cardiologists, pathologists and clinical pathologists should be included in group hospital projects, since, as has been stated in the journals of the Hospital Association, they cannot be considered practicing physicians because 'they merely carry out the orders of practitioners of medicine—are subordinates—and assume no responsibility to the patient'." How any hospital can divorce the important professional services of any of the above-mentioned physicians and pretend they are fulfilling their obligations to their patients is something difficult to understand. The important question, however, is how the inclusion is to be made.

This problem is one of vital importance. Unwise and unjust decisions will surely lead to consequences that may be disastrous: to the public, to physicians and even to the hospitals. The establishing of ethical and just standards for physicians holding hospital positions, in any scheme of group hospital projects, is absolutely necessary. Any system of group hospital insurance is a contractural one between the insurers and the hospital for "hospital services." What constitutes hospital services? As has been emphasized before it is the staff that makes a hospital, not a set of ornate and imposing buildings, and to deny any member of the staff due recognition, exploit his services in any way or refer certain studies to a non-medical personnel should be met with emphatic objections from the entire profession.

(1) *Journal A. M. A.*, Vol. 112, Number 9, 869.

Patients enter hospitals for a certain purpose. The job of the hospital—by means many times of the combined efforts of the entire staff—is to restore a given patient to health if it is possible. If that end cannot be accomplished legitimate reasons must show why. To designate physicians working in highly technical and specialized lines, to be sure many of them are not in private practice and cannot be under the conditions they work, as "ancillary" workers in clinical medicine raises a most important question. If they are not practicing medicine what are they doing? Much of scientific medicine today is founded on the researches and their clinical adaption of pathologists and clinical pathologists. It is an admitted fact that in many major surgical procedures the anesthetist is a most important member of the surgical team. The demands made by many of the present-day highly technical surgical procedures has required of the anesthetist a most exacting preparation for his specialty. The modern radiologist is most emphatically not a physician who is skilled, merely in the "taking of X-ray films." That indeed is a small part of his job and in busy clinics technicians properly take over routine work of this type. What modern medicine asks of the roentgenologist is his interpretation of the evidence disclosed by his study of a given case. He must be skilled, he must be a physician capable of interpreting the evidence before him in terms of clinical fact and the most of us rely on his judgment and advice; if we have common sense.

All of these physicians are and must be regarded as colleagues and in no way separate and apart from clinical medicine. All physicians should be grateful that such services are at our call; most of us ARE.

Eighty-Seventh Annual Session
Program in Brief

Sunday, June 25th

Golf Preliminaries.

4.30 P. M. First meeting of the House of Delegates.

8.30 P. M. Entertainment for the doctors and their wives, by a nationally known prestidigitator.

Monday, June 26th

9.30 to
12.00 A. M. Conferences.

12.30 P. M. Luncheon.

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill, and Harvard University Medical Schools.

Golf Preliminaries.

12.00 to
2.00 P. M. Motion Pictures, Medical.

2.00 to
4.45 P. M. Clinical-Pathological-Scientific Session.

5.00 P. M. Election of President-elect.

5.30 P. M. Second Meeting of the House of Delegates.

7.00 P. M. Dinner and Dancing.

9.00 P. M. James S. Greene, M. D., New York City, "Speech Defects."

Tuesday, June 27th

9.30 to
12.00 A. M. Conferences.

12.30 P. M. Past Presidents' and County Secretaries' Luncheons.

12.00 to
2.00 P. M. Medical Motion Pictures.

2.00 to
5.00 P. M. Scientific Session.

Golf Finals.

7.00 P. M. Banquet (dress informal).

Introduction of Visiting Delegates and Guests by President Willard H. Bunker.

Presentation of Fifty-Year Service Medals.

Guest Speaker: Morris Fishbein, M. D., Editor of the *American Medical Journal,* "American Medicine and the National Health Program."

To the Ladies

Our president's most genial wife has taken it upon herself to see that we give the women an extra break this year. All of the evening sessions have been made specially attractive for the ladies. There will be dinner dancing on Monday evening. Monday and Tuesday afternoons there will be bridge parties with suitable prizes. Automobiles will be provided for a number of sight-seeing trips. We also have some fine motion pictures for the women who do not play bridge.

Golf Tournament

This is our second annual handicap golf tournament. Last year, on account of the rain, at Bar Harbor, we had only a few contestants. Doctor Forrest Tyson of Augusta, Maine, has promised to take care of the running of the tournament.

We can assure you that the course is one of the best, and the prizes are well worth the fun and effort.

Convention Rates

Poland Spring House
Poland Spring, Maine

The following Room Rates, which include all meals, will prevail:

Single Rooms without bath	$6.00 per day
Double Rooms without bath	6.00 per day, per person
Double Room and Single Room with connecting bath, for 3 persons	7.00 per day, per person
Two Double Rooms with connecting bath for 4 persons	7.00 per day, per person
Double Room with bath for 2 persons	7.00 per day, per person
Single Room with bath	8.00 per day, per person

The charge for non-registered guests for meals will be as follows:

Breakfast	$1.50
Luncheon	2.00
Dinner	2.50

Golf green fees will be $1.00 per day. The tennis courts and Beach Club will be available without charge.

The Hotel Orchestra will be available four hours each day for dancing.

Poland Spring Water, both Natural and Carbonated, will be served at all times to the guests of the Hotel.

Continued from page 97

In proof of our statement of the 1937 survey in Aroostook County: "Most soils, if not made to produce crops, will produce ragweed; it is evident that soils, like human beings, should be kept busy", read the very comprehensive illustrated story of pollens by Director R. P. Wodehouse of the Hayfever Laboratory at Yonkers, N. Y., in the March, 1939, Natural History Magazine:

"The increase of ragweed hayfever in the United States results from more denuded soil. . . . Nature demands that land be clothed. If we do not like her choice of weeds, we may select our own. . . . Let land revert to forest which kills out ragweed, or cultivate intensively. . . . Waste means weeds and hayfever."

Committee Reports

Legislative Committee

To the Officers and Members of the Maine Medical Association:

The Legislative Committee wishes to submit the following report for the year 1938-39:

It was necessary to call two full meetings of the Legislative Committee,—one at the Augusta House in January, at which time only two members were absent.

The second meeting was held at the Worster House at Hallowell on the evening of February 8th with an equally good attendance.

At our January meeting a goodly store of bills appeared to be lining up for the term of Legislature at Augusta and it was voted that with the approval of the Council a stipulated sum should be paid our attorney, Mr. Herbert E. Locke, and that as far as possible he would represent the Maine Medical Association at the Legislative Term in Augusta in opposing any bills proposed at that session that appeared unjust.

It was also voted at the January meeting that members of our Association avoid appearing before the Legislature unless at the request of Mr. Locke.

A committee consisting of three members was appointed for the purpose of consulting freely with Mr. Locke on all legislative matters and this arrangement has proven very satisfactory.

Among the numerous questions that have confronted us I might mention the Medical Examiners' Bill, the Osteopathic Bill, the Uniform Narcotic Drug Act, the Maternity and Obstetrical Act, the Barbital Bill and the Bill on Nursing Requirements.

The Legislature is still in session and all of these bills have not been disposed of but it is indeed gratifying to report that the final results will be most satisfactory.

The Legislative Committee wishes to extend their thanks for the hearty coöperation of the Maine Hospital Association, Maine Nursing Association, and many of our members throughout the State who were not directly connected with this committee.

It has indeed been a difficult year but due to our unity of purpose and perseverance we feel duly repaid and that our time and energy have not been spent in vain.

Respectfully submitted,

Willard H. Bunker,
Chairman.

Cancer Committee

A review of the activities of the Cancer Committee reveals evidence of individual and collective coöperation, rather than separate endeavor of the Committee as a functioning unit. In other words, the work of the members of the Cancer Committee has been so closely tied up with the public activities of the Women's Field Army for the Control of Cancer, that there has been little room for other projects by the Cancer Committee as such.

However, it would seem that this particular method of presenting constructive Cancer work has not been without definite evidence of progress.

The educational campaign of the Women's Field Army has been eminently successful. To this campaign various members of the Cancer Committee have contributed much in personal time and effort. Speaking before lay groups and by radio, the medical aspects of cancer have been frequently presented. Positive results of this campaign have been noted in the steadily increasing number of individuals who have visited the Tumor Clinics for advice and treatment.

No new Tumor Clinics have been added during the past year. The list is made up as follows:

Central Maine General Hospital, Lewiston.
Eastern Maine General Hospital, Bangor.
Maine General Hospital, Portland.
Sister's Hospital, Waterville.
St. Mary's General Hospital, Lewiston.
Thayer Hospital, Waterville.

Members of the State Cancer Committee have served as Clinic personnel, along with other members of the institutional staff.

Figures from the office of the Women's Field Army show that the Joseph W. Scannell Memorial Fund was exhausted October 1, 1938, so great was the increase in demand for services to the indigent. Benefits from this fund were widely distributed throughout the State.

The question has been brought up of placing other diagnostic clinics at strategic points in the State not now easily covered. These would serve to lighten the load on some of the larger centers. A study of this problem is now going on and key men are being contacted with the idea of inaugurating such diagnostic centers.

Because of the requirements of high-voltage roentgen therapy and radium, only the larger clinics are likely to carry on the therapeutic measures of radiation.

Early in the year a symposium on cancer was prepared by a committee member, Edward H. Risley, M. D., of Waterville, Dr. Risley acting also in his capacity as Chairman of the Advisory Board of the Women's Field Army. Contributions to this symposium were made by members of the State Association Cancer Committee and other medical members of the Women's Field Army Advisory Board. Under appointment, requested by the Committee on Graduate Education, Dr. Risley plans to offer this symposium for panel presentation at County Medical Society meetings.

In review it may be stated that cancer work in the State of Maine is much more active than it has been for years. The educational activities of the Women's Field Army for the Control of Cancer, backed by the personal and professional coöperation of members of the Maine Medical Association, are helping the laity, as a whole, to become more and more cancer-conscious. The biggest problem now seems to be to synchronize the educational work with funds available for carrying the increasing load of indigent patients, seeking treatments for cancer.

Forrest B. Ames, M. D.,
Chairman Cancer Committee,
Maine Medical Association.

Publicity Committee

To the Officers and Members of the Maine Medical Association:

The Chairman of the Publicity Committee reports that the only official releases for newspaper publication during the year were the notices and programs of the Clinical Session held in Lewiston during November, 1938.

The Chairman wishes to take this opportunity to advise members that the Council believes that the best interests of the Association require that an authorized committee assume the responsibility for the newspaper publication of any organization affairs.

Respectfully submitted,

Thomas A. Foster, M. D.,
Chairman.

Committee on Graduate Education

To the Officers and Members of the Maine Medical Association:

The Committee on Graduate Education respectfully submits the following report:

One of the most important responsibilities facing State Medical Associations is that of providing an adequate program of Graduate Education. The problem varies in different States, due to many local factors. Consequently there is bound to be considerable variation among the several programs which are being developed. A permanent organization of the different State Committees on Graduate Education has been effected, for mutual benefit and exchange of ideas. Your chairman has attended each meeting of this central organization and plans to be present at the next meeting in St. Louis at the time of the meeting of the American Medical Association.

Your committee has had several meetings during the year and has been in conference with the Council and the County Secretaries.

Because of the unique advantage accruing to our State through the Bingham and the Commonwealth Fellowships our program naturally becomes divided into two parts: one, intramural, concerned with making

available adequate educational programs within our State; and the other, with the wider utilization by our members of courses available in Boston.

It was decided to develop our intramural program in conjunction with the County Societies. After some experimentation, in an endeavor to find the most interesting type of program, a series of Panel Discussions were prepared and offered to the different County Societies. Panels on the following subjects are now available: "Pneumonia," "Cardio-Vascular Disease," "Fractures," "Acute Appendicitis and Complications," "Laboratory Methods and Their Application in Clinical Medicine," "Surgery of the Thorax" and "Cancer." It is expected that panels will be developed upon other subjects from time to time, depending upon the demand. So far this type of program has seemed very popular and worthwhile.

Your committee has coöperated with the Directors of both the Bingham and the Commonwealth Funds in an endeavor to have the available Fellowships allocated where most needed. For the most part these Fellowships hithertofore have been designed for men practicing in the smaller communities. As near as can be estimated about 15% of our membership have taken advantage of these Fellowships. Perhaps another 10% have been providing their own educational program, independently — through long-established hospital or society affiliations — and need not enter into the problem.

Of the remaining 75%, eliminating the men near retirement age, there must be about 50% who should have available, facilities for some form of Graduate Study. An intramural program is essential in order to reach these. In turn this may stimulate interest in some phase of our extramural program. At present it does not seem necessary to further expand our program but rather to coördinate and develop what we already have. The sole exception to this might be where, in certain counties, such as Aroostook, the geographical problem makes it difficult for men to attend meetings, especially during the winter. Here it might be well to consider the question of intensive intramural courses — to be given during the summer. If there be sufficient local interest, such a program can be developed and financed without expense to the local groups. It is understood that the Bingham Associates are developing another form of Fellowship, giving short, intensive courses of one week's duration and covering more concrete subjects. These will provide study on more specialized subjects than hithertofore available and should appeal to a greater number of our members.

Recommendations:

(1) Greater coördination between the programs of the Annual June Meeting and the Fall Clinical Session, and the program of Graduate Education. While there is no desire to interfere with the committees having in charge these two annual events, the Committee on Graduate Education necessarily must have a long-range viewpoint, and coöperation between these committees might result advantageously for all concerned.

(2) Continuation of the Panel Discussion type of program—through the County Societies.

(3) Further development of the Hospital Staff program, utilizing the material available for case study. "Education Should Begin at Home."

(4) Participation of the State Association as an organization in the New England Post-Graduate Medical Assembly. This has already proved its usefulness and is a "going concern." It offers a great deal in the way of Graduate Education.

(5) Coöperation with the Bingham and the Commonwealth Funds in the extramural program—through greater utilization of the available Fellowships. Courses on any desired subjects may be obtained for groups of four men—through application to the Committee.

Respectfully submitted,

Frederick T. Hill, M. D.
Julius Gottlieb, M. D.
Norman H. Nickerson, M. D.
Frank H. Jackson, M. D.
Eugene E. Holt, Jr., M. D.

Advisory Committee on Syphilis Control

To the Officers and Members of the Maine Medical Association:

The Committee presents the following report received from Roscoe L. Mitchell, M. D., Assistant Director of the State of Maine Department of Health and Welfare.

State of Maine
Venereal Disease Statistics

Calendar Year 1938

"During the year the director of the division gave 36 lectures mostly to lay persons on the subject of venereal disease, the total attendance being about 3,300 persons. About 800 pieces of educational literature were sent out in response to requests.

The Diagnostic Laboratory performed 19,080 Kahn tests and 17,658 Hinton tests. Examinations for the presence of gonococci totalled 5,827, 1,162 of these being performed at the Branch Laboratory in Caribou.

No record is available of the amount of treatment for syphilis given by private physicians. The Bureau of Health receives reports from the twenty-seven state clinics and their totals for the year 1938 list 11,846 doses of arsenicals and 12,948 doses of heavy metals.

During 1938, 58% of the newly reported cases of syphilis were attending the clinics, whereas 60% of the new cases of gonorrhea were being treated by private physicians.

Case reports give a total for 1938 of 588 cases of gonorrhea, 487 being acute, 90 chronic and 11 not stated. Of syphilis 572 were reported, the stages being as follows: 95 primary; 139 secondary; 289 tertiary; 36 congenital; 8 latent and 5 not stated.

Free drugs of all sorts were issued by the Bureau to 130 physicians during the year 1938, exclusive of the material furnished to the state clinics."

Benjamin B. Foster, M. D.,
Chairman.

Report for the Committee on the Prevention and Amelioration of Deafness

The outstanding accomplishment to be reported for the year is that of the purchase, by the Bangor School Department, of an audiometer for mass testing and final testing of school children.

This move will make it possible for the surrounding communities to have the use of an audiometer, also, at a very normal charge.

It is felt that this move will be a step forward in remedial and preventative care in another section of the state.

Harry Butler,
Chairman.

Cancer Notes

A recent report from the Mayo Clinic of six cases of Hodgkin's disease localized in the stomach again calls attention to a diagnostic problem of interest to surgeon and pathologist alike. The relatively infrequent accounts in the literature doubtless undervaluate its actual occurrence. Many cases diagnosed as inoperable gastric carcinoma without biopsy or operation fall under this heading, as well as occasional cases classified by the pathologist as atypical carcinoma or lymphosarcoma. —Seaton Sailer, M. D., *The Southern Surgeon,* Dec., 1938.

It is recognized that any woman manifesting abnormal uterine bleeding should have a diagnostic curettage. — Dr. K. C. Morrin and Dr. Paul F. Max, in *Surgery, Gynec. & Obs.,* Jan., 1939.

Maine Medical Legislation

1939 Maine Legislature

1. *Original L. D. 873.* Hospitals must admit to practice in them osteopaths and must do all laboratory work required by osteopaths. *Killed in the last week of the session.*

2. *Original L. D. 22.* Dr. Pratt's amendment to Medical Examiners' Bill. *Finally passed in the last week of the session after a very stormy career.* Essential changes: Number reduced to two each in the counties of Franklin, Hancock, Knox, Lincoln, Piscataquis, Somerset, Sagadahoc and Waldo; three each in Oxford and Washington; four each in Aroostook, Kennebec and York; five in Androscoggin; six in Cumberland and Penobscot. Governor may appoint as many more as he considers advisable, repealed. But law not to take effect until January 1, 1941, i. e., after present Governor retires from office. Consequently, present Governor will not be embarrassed by failure to reappoint.

3. *Original L. D. 581.* Sale of opium derivatives only on prescription. *Passed.*

4. *Original L. D. 472.* Sale of barbituric acid derivatives or compounds only on prescription (except for personal administration by a doctor, dentist or veterinary to his own patients). *Passed.*

5. *Original L. D. 820.* Dispensation of marijuana forbidden. *Did not pass.*

6. *Original L. D. 874.* Hospitals (and inferentially others) may charge only $3.00 each for X-ray pictures. *Did not pass.*

7. *Original L. D. 880.* United States Uniform Narcotic Law. *Did not pass.*

8. *Original L. D. 471.* Requiring pre-marital examination for venereal diseases. Amended to require merely a prenatal examination. Requires every physician to take during gestation a blood test and submit to the State Laboratory. Rushed through in this last amended draft during the last week of the session. Got it recalled from Governor's office and had the words added, "and no civil action shall be maintainable for failure to comply with this act." *Reason:* The law says a doctor must take the blood test of the patient. Of course, this won't be done in many instances. To be sure, the consent of the patient is required. But in making a malpractice claim, the patient could and from previous experience in some instances would claim that she gave the consent. That the doctor had not taken the test which the law demands could well be claimed to be malpractice. Consequently, this amendment to avoid malpractice suits.

9. *Original L. D. 606.* Lien on casualty insurance proceeds for hospitals. *Did not pass.*

10. *Original L. D. 57.* Creating office of State Pathologist, earnestly supported by attorney-general. *Did not pass.*

11. *Original L. D. 537.* Compensation Act. Employee may select his own physician in industrial injury. *Did not pass.*

12. *Original L. D. 612.* Non-profit hospital corporations authorized. *Did pass.*

13. *Original L. D. 938.* Boards of registration, including that of medicine, may suspend the license fees if and whenever there is enough money on hand to warrant it. *Did pass.*

14. *Original L. D. 322.* Incorporating the Associated Hospital Service of Maine (Socialized Hospital Service). *Did pass.*

15. *Original L. D. 600.* Optometrist Bill.—Forbidding optometrists to practice when hired out, as to chain stores. *Passed.* Stormy career and in doubt up to the last end of Legislature. But probably ineffective for the purpose it seeks. Because the stores employing the optometrist will have written contracts with them and probably can by injunction and in equity prevent the operation of the law to defeat their rights under the written contracts.

16. *Original L. D. 755.* To create a licensing department in the hands of one man to take over completely all the powers of the various boards of registration including medicine. *Did not pass.*

17. *Original L. D. 811.* Permits blood-grouping tests in bastardy cases and makes the testimony of examining physician admissible. Heretofore such evidence unacceptable in Maine courts. *Passed.*

18. *Original L. D. 546.* Commitment may be made of insane not only to State hospitals as heretofore but to the Government hospitals as well. *Passed.*

19. *Original L. D. 1152.* Law suits to recover for so-called "death without conscious suffering." Right to recover "the reasonable expense of medical, surgical and hospital care and treatment" added. *Bill passed.* Heretofore in so-called "instant death" cases, i. e., wherein the deceased never recovered consciousness after the injury, any such incidental expense could not be recovered.

County News and Notes

Cumberland

A meeting of the Cumberland County Medical Society was held Friday, April 21, 1939.

The following cases were presented at a Clinic at the Maine General Hospital at 4.30 P. M.:

"Tri-malleolar Fracture" — William L. Casey, M. D.

"Transient Visual Disturbance during Diabetic Regulation"—E. R. Blaisdell, M. D.

"Diagnostic Problem"—Harold M. Cutler, M. D.

"Pituitary Tumor"—Thomas A. Foster, M. D.

Dinner at the Eastland Hotel at 7.00 P. M. was followed by a brief business meeting at which G. A. Pudor, M. D., and Charles B. Sylvester, M. D., were proposed for Honorary Membership. The applications of Gordon N. Johnson, M. D., Portland, and Philip Gregory, M. D., Boothbay Harbor, were referred to the Council for consideration.

Richard H. Overholt, M. D., of Boston, was the speaker of the evening. Dr. Overholt's subject was "Some New Developments in the Management of Chest Lesions."

Kennebec

A meeting of the Kennebec County Medical Association was held at the Gardiner General Hospital on Thursday, April 20, 1939.

Clinical Session at 5 P. M., which was presided over by Leon D. Herring, M. D., President.

(1) A case of laryngeal edema—A. C. Hurd, M. D.

(2) A case of persistent jaundice—M. D. Shelton, M. D.

(3) Ablatio placenta—I. E. McLaughlin, M. D.

(4) Two cases of intussusception—F. B. Bull, M. D.

(5) A case of Buerger's Disease—C. R. McLaughlin, M. D.

(6) Metastasis Malignancy—C. R. McLaughlin, M. D.

(7) Premature Separation of Placenta; Cæsarian Operation—S. H. Kagan, M. D.

Dinner at 6.30 P. M., followed by a business meeting.

Minutes of the last meeting were read and approved.

The application of Nathan Rosenberg, M. D., Togus, Maine, was received and referred to the Board of Councillors.

The speaker of the evening was Samuel A. Levine, M. D., F. A. C. P., Assistant Professor of Medicine, Harvard Medical School; Associated with Peter Bent Brigham Hospital, Newton Hospital, and New England Baptist Hospital. Dr. Levine's subject was "Ausculation of the Heart." He discussed different murmurs, arrhythmias, pulsus alternans, and tachycardias. He emphasized the use of the right type of stethoscope, stating that certain murmurs could be heard best with the bell-type and others with the flat chest piece. The address was ably presented and a great deal of discussion followed.

There were 41 members and guests present.

Respectfully submitted,

Frederick R. Carter, M. D.,
Secretary.

Hancock, Knox, Waldo, Joint Meeting

A joint meeting of the Hancock, Knox and Waldo County Medical Societies was held at the Windsor Hotel, Belfast, on March 23rd.

Following the banquet, the Waldo County Society held a brief business session, with the President, Dr. F. C. Small, in the chair. The following officers were elected for 1939:

President, E. L. Stevens, Belfast.

Vice-President, G. F. Miller, Belfast.

Secretary-Treasurer, R. L. Torrey, Searsport.

Member of Board of Censors for three years, S. C. Pattee, Belfast.

Delegate to the Maine Medical Association Annual Session, F. C. Small, Belfast.

Alternate, C. H. Stevens, Belfast.

The scientific program consisted of a panel discussion of fractures, sponsored by the Committee on Graduate Education, and under the chairmanship of Dr. Allan Woodcock of Bangor.

Dr. Woodcock spoke on general considerations of fractures.

Dr. F. B. Ames of Bangor on the X-ray angle of fractures.

Dr. C. C. Corson of Portland on fractures of the spine.

Dr. W. V. Cox of Lewiston on skull fracture and head injuries.

Dr. Howard Hill of Waterville on eye-ground findings in head injuries.

Dr. C. H. Stevens of Belfast on fractures of the hand.

All the papers were interesting and were well received, and a general discussion followed.

Twenty-six physicians were present, representing Portland, Belfast, Waterville, Lewiston, Bangor, Rockland, Camden, Thomaston, Bar Harbor, Ellsworth, Southwest Harbor and Searsport.

Raymond L. Torrey, M. D.,
Secretary, Waldo County Medical Society.

York

Report of the Quarterly Meeting of the York County Medical Society.

The regular April meeting was held on the 12th at the Kennebunk Inn. Dinner was served at 1 P. M.; the meeting followed, with twenty-two members and four guests present.

The meeting was opened by President Mayo, and the following business was transacted:

Minutes were read and approved.

Dr. Richards' application for membership was accepted.

The Committee appointed to take charge of the Summer Meeting were: Doctors Cobb, Hill, Jr., Dolloff, and Kinghorn. It was decided to accept the invitation from the Cumberland County Society to join them for that meeting.

The Committee appointed for the October meeting were: Doctors E. M. Cook, MacDonald, G. Smith, and Kinghorn. It is to be held at York Harbor, Maine, at the Hillcroft.

Dr. Foster of Portland talked on the condition of the two Societies. Dr. Foster is Councillor for the First District.

Dr. Pepper, District Health Officer, made a few remarks and offered to answer any questions.

Dr. Cobb, Chairman of the Program Committee for the State Convention, gave a resumé.

Dr. Dolloff read a very interesting letter in regard to the outcome of the Aroostook County controversy.

Dr. Corson of Portland lectured on Emergency Treatment of Fractures, followed by a film on First Aid regarding the topic.

Dr. Kinghorn showed some interesting slides on ear conditions.

C. W. Kinghorn, M. D., *Secretary.*

New Members

York

Carl E. Richards, M. D., Alfred.

Removal Notice

Ralph Heifetz, M. D., announces his removal from 712 Congress Street, Portland, to 717 Congress Street, Portland.

Important Coming Meetings

American Medical Association

American Medical Association, St. Louis, May 15-19, 1939

State Medical Associations

Connecticut State Medical Society, New Haven, May 25-26. Creighton Barker, 258 Church Street, New Haven, Connecticut, Secretary.

Maine Medical Association, Poland Springs, June 25-26-27. Frederick R. Carter, 22 Arsenal Street, Portland, Maine, Secretary.

Massachusetts Medical Society, Worcester, June 6-7-8. Alexander S. Begg, 8 Fenway, Boston, Massachusetts, Secretary.

New Hampshire Medical Society, Manchester, June 8-9. C. R. Metcalf, 5 S. State Street, Concord, New Hampshire, Secretary.

Rhode Island Medical Society, Providence, June 7-8. Guy W. Wells, 124 Waterman Street, Providence, Rhode Island, Secretary.

Vermont State Medical Society, Burlington, 1939. Benjamin F. Cook, 46 Nichols Street, Rutland, Vermont, Secretary.

American Congress on Obstetrics and Gynecology Committee on Maternal and Infant Welfare

The American Congress on Obstetrics and Gynecology is sponsored by the American Committee on Maternal Welfare. This Committee is composed of member organizations, with a representative from each forming the Board. The member organizations include the various national and sectional obstetrical and gynecological associations, hospital associations, public health organizations, and nursing associations.

The Central Association on Obstetrics and Gynecology proposed an American Congress on Obstetrics and Gynecology to study the present-day problems on obstetrics and gynecology and their solution. The American Committee on Maternal Welfare was asked to sponsor this Congress. The Congress will be held in Cleveland, Ohio, September 11 to 15, 1939. The Committee expresses the purpose of the Congress, "To present a program of our present-day medical, nursing, and health problems, from a scientific, practical, educational, and economic viewpoint as far as they relate to human reproduction and maternal and neonatal care." This Congress is not in any sense a legislative body and naturally will take no action relative to maternal and infant care.

There will be sessions for each professional group in the morning, with round-table discussions. The afternoon meetings will have papers of general interest to all members attending the Congress. The public will be invited to the evening sessions, where there will be speakers of national prominence.

The program for the physicians will include among many others such subjects as pregnancy associated with: thyroid disease, heart disease, diabetes, tuberculosis, nutritional factors, carcinoma of the female genitive tract, and abortions.

The Congress is not planned as a meeting for specialists in any sense of the word, but for all physicians who are interested in the problem of maternal and child welfare. Your Committee highly recommends this Congress as a week of postgraduate work which should be worth while much more to the physician than the time and expense incurred for the trip. The physicians of this State should be well represented at this Congress.

The membership fee of $5.00 includes membership in The American Committee on Maternal Welfare and registration in The American Congress on Obstetrics and Gynecology. Application blanks and further information may be secured from your chairman, Roland B. Moore, M. D., Portland, Maine, or from The American Congress on Obstetrics and Gynecology, 650 Rush Street, Chicago, Illinois.

Necrologies

Edson S. Cummings, M. D., 1875-1939

The State of Maine, as well as the City of Portland and the medical societies, have lost a valued friend and helper in the death of Doctor Edson S. Cummings. He was born in Lewiston, Maine, December 7, 1875, and died at his home in Portland, April 11, 1939. He received his early education in Lewiston and graduated from Bowdoin Medical School in 1900. He interned at the Central Maine General Hospital, afterward entering general practice in Lewiston. He was on the active staff of the Central Maine General Hospital until he entered the World War.

During the World War Doctor Cummings was stationed at Camp Funston, Fort Riley, Kansas, being in charge of the X-ray work at the hospital there, following special work at the Military School of Roentgenology at Kansas City, Missouri. He was on duty at Fort Riley until January 8, 1919, when he was honorably discharged, holding the rank of captain at that time.

On his return to Maine he located in Portland, where he has been in active practice since. For twenty years he was on the staff of the Maine Eye and Ear Infirmary.

Doctor Cummings was one of the founders of the Medical Research Club of Lewiston and took an active part in the County and State Associations. He was a member of the Maine Medical Association and the American Medical Association. He was also a member of the Masonic Order, Kora Temple, Order of the Mystic Shrine, the Portland Lions Club, and was active in the Medical Reserve Corps.

Our heartfelt sympathy goes to his wife, Harriet, and his son Philip.

Gilbert M. Elliott, M. D., 1867-1939

Doctor Elliott, who practiced medicine in Brunswick nearly half a century, died at Brattleboro, Vermont, April 1, 1939.

Born in New York City, March 26, 1867, he was graduated from the City College of New York in 1886, received his degree of Doctor of Medicine from Columbia University in 1889 and the degree of Master of Science from the City College of New York in 1890. On August 13, 1890, he married Miss Belle Vennard Merryman, of Brunswick, who survives him.

Doctor Elliott began the practice of medicine in Brunswick in 1892. After four years he went to Europe and studied at Vienna and Munich, returning to Brunswick in 1900. He served Brunswick for many years on the board of health and for twenty-seven years was a member of the school committee.

Doctor Elliott held the rank of first lieutenant and assistant surgeon in the First Maine Infantry during the Spanish-American War, when he was assigned to the divisional hospital at Chicamauga. He was in charge of the hospital train that returned to Maine ahead of the troop trains. He gradually advanced to the rank of major in the National Guard and was transferred to the Medical Corps, being in charge of the medical unit of the Maine National Guard, which was on duty in Halifax following the explosion in 1917. During the World War he was assigned to the Bowdoin College unit as medical officer in charge of infantry training. He retired from the Maine National Guard a few years ago with the rank of Lieutenant Colonel.

Doctor Elliott was a member of the Maine Medical Association, the Association of Military Surgeons, the Association of American Anatomists, Spanish-American War Veterans, and American Legion.

Surviving, besides his wife, are a son, Gilbert M. Elliott, Jr., of Portland, and a daughter, Mrs. William D. Ireland of Massachusetts.

Correspondence

Robert E. Jewett, M. D.,
Chairman,
May Day Child Health Committee.

Dear Dr. Jewett:

In connection with the splendid program that is being developed for May Day in protection of the lives and health of mothers and children, we should not forget that, in the State of Maine, we still have a problem that must be given special consideration.

During 1938 we had almost three times as many deaths from diphtheria as we had in 1937. We have also had more cases of diphtheria. Let us, then, urge all parents to have their children protected at once so that, when the incidence of diphtheria begins its seasonal rise in the fall, they may be happy to know that their children have been guarded against this dread disease.

I would appreciate it if you would keep this in mind when developing your publicity program.

Sincerely yours,

(Signed) Roscoe L. Mitchell, M. D.,
Assistant Director of Health.

Book Review

"The Vaginal Diaphragm—Its Fitting and Use in Contraceptive Technique"

By Le Mon Clark, M. S., M. D., Chicago, Ill. Author of "Sex Education" and "Emotional Adjustment in Marriage."

Published by the C. V. Mosby Co., St. Louis, Mo., 1939. Price, $2.00.

In this small, well-illustrated monograph the author attempts to give full instructions for the execution of the technique of contraception by the combination employment of the flat spring hemispherical vaginal diaphragm and vaginal jelly or cream. Apparently the author's intentions were to instruct the patient in how she can best serve herself after her physician has correctly fitted her with the anatomically most appropriate size of diaphragm. It is claimed that those who follow the author's instructions will find the method reliable and the technique convenient and reasonably clean.

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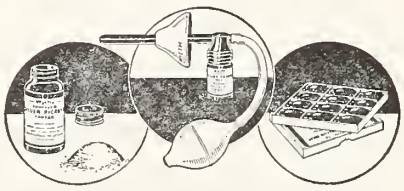

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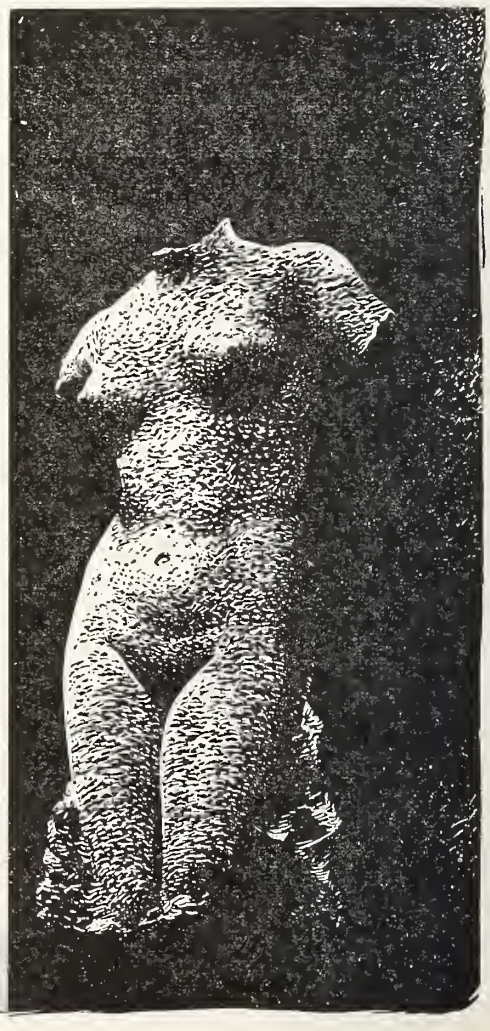

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*The Legal Status of the Intern**

By Fred Ellsworth Clow, M. D., F. A. C. P.,
Secretary of the New Hampshire State Board of Registration in Medicine

INTERN: A resident or indoor physician or surgeon (Dorland).
Syn: House Officer: House Physician: or House Surgeon.

In the last quarter century twenty-one states and Alaska have made the hospital service a requirement for licensure. Some medical schools withhold the degree until one year at least has been served. In 1938 the Council on Medical Education and Hospitals reported for the United States 7354 internships in 729 approved hospitals and for Canada 48 approved hospitals. A change has been noted in the place of the intern in the educational scheme. Whereas, in the past the service in the hospital was considered postgraduate training, and optional with the student, longer training as a resident is now required, and the intern is regarded more as an undergraduate, still pursuing his medical course, learning the art as well as the science of medicine. With increased responsibility has come the necessity for wider knowledge, more maturity of judgment and better poise.

When the intern enters the hospital he learns, for the first time in his life that he is liable for his acts, not only as an individual member of society, but as a professional man. Besides once the medical student comes in intimate contact with patients he is amenable to the statute governing the practice of medicine in his state. For the first time his every word and every act is scrutinized, often remembered, and frequently misunderstood by a person rendered hypercritical by illness. The intern can, by a thoughtless remark alone cause a malpractice suit for the physician referring the patient. Observations concerning previous diagnosis and treatment are particularly dangerous, because the patient rarely understands and never correctly describes any medical opinion or procedure.

With improvement in the technic of diagnosis and treatment, and the consequent increase in mechanical manipulations, the opportunities for costly mistakes are enormously increased. Thoughtful men in all departments of medicine are disturbed at the way in which litigation is increasing, the ease with which it can be started, the complicated,

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costly, and to physicians the cumbersome methods of the law. They are astounded at the ease with which the slightest slip in technic is magnified when presented to a jury of laymen, and the difficulty of getting the truth to prevail. The hospital may protect its property and its employees; the visiting staff can rely on the insurance company to assume liability. Apparently the intern, if attacked as an individual is without protection. One insurance company in New England, with long experience in this field, offers no way in which the intern may be covered. Another company specializing in liability insurance replies: "Our Hospital Policy covers the liability of a hospital on account of the negligent acts of interns, resident physicians, and medical students. It will not, however, cover the liability of resident physicians, interns or medical students themselves." Insurance companies demand a certain competence, experience, medical society membership and the good opinion of men of the same standing. House officers cannot yet meet these standards. Besides, it appears that if a liability contract were devised the high cost would be a deterrent to many young men still under expense of education. Until the legal status of the intern is determined by precedents, or better by statute the hospital can scarcely afford to insure him.

The hospital has a selfish interest in protecting the intern from himself for its own salvation. One can but feel that too often the intern is given too much latitude in the conduct of ward service. No one believes today that an internship prepares any man to become a safe, conservative surgeon. And that often appears to be the aim of the student himself. Some of the dissatisfaction existing in unnecessary and harmful operative work done in private practice springs from the practice of permitting the house surgeon to do by himself operations for which he is not trained.

Many hospitals with a small resident staff require much routine administrative duties and the assumption of altogether too much responsibility in the performance of technical procedures. Hospital administrators complain that the intern is poorly prepared to do his job.

As has been pointed out by more than one hospital executive the intern is entitled not only to the conventional precedent book of routine matters, but he should be introduced to his new duties by someone who will be a sympathetic adviser, who can interpret to the newcomer methods and customs of that hospital, in which otherwise he may grope and stumble during his whole appointment.

He should be taught that hospitals are complicated organisms, serving in a most personal manner the public made up of all types of individuals, dealing with persons sensitized by illness, with relatives and friends even more demanding and more critical. The opportunities for trouble in the hospital exist in every procedure, every minute of the day, and involving every employee and officer, and every physical feature of the plant.

The intern is charged with the duty of carrying out the instructions of the attending physician except in emergency. When an emergency arises it is incumbent on the intern to exercise his own judgment until report can be made to and instructions received from the attending physician.

The intern may be charged with failure to obtain consent for an operation from a husband or the parent of a minor. Care must be used that state laws be observed. Permissions should be reviewed by the superintendent's office. He is liable for malpractice in the case of a minor, to the majority of the patient and whatever the statute of limitations may be beyond that; in one state to the age of twenty-three.

In obtaining permission for necropsy the intern must get the signature of the right person, preference being given to the relative who assumes control of the body, bearing in mind that a minor cannot grant permission, though he is the sole survivor. One must be certain that the person granting permission clearly understands the nature of the necropsy, and that the scope is definitely established, as well as understood and followed by the pathologist. Where the coroner system prevails one must be careful in doing autopsies on the orders of that officer. Limitations of his power exist and outraged relatives may cause difficulty. Every city has regulations as to what constitutes medico-legal or "Medical Examiner's" cases, including abortions,

prisoners, wounds and deaths from criminal violence. Failure to report such may be serious for the hospital.

The house officer is amenable to the law, and held for his acts in privileged communications, in the same way as physicians in private practice. He is forbidden to communicate with patients for the purpose of engaging the services of attorneys; he is forbidden to report deaths to, or recommend particular undertakers. He may be summoned to court with hospital records and compelled to testify to facts. Interns must respond to subpœna, but hospitals may and sometimes do refuse to disclose the names of members of the house staff who have treated patients involved in lawsuits, because much time is lost in attending court. An intern at a charity hospital referred accident cases which he had solicited to two attorneys. Although he denied an agreement, he fully expected to be paid. He was advised to plead guilty to the charge and was sentenced to three months in the penitentiary. The intern is subject to the national and state income tax laws. The superintendent of the hospital returns to the tax authority each year the list of employees having a minimum income, with board and living, if furnished, computed at approximately $500 per year.

Many hospitals are getting a larger number of personal injury, street accidents and compensation cases than ever before. Larger numbers of citizens come within the categories covered by various types of protection. The intern will treat many more of these cases in a short service than the private physician. The hospital should, therefore, have a clearly defined routine for his guidance, since the payment of the hospital bill, and the patient's chances of financial recovery depend so much on prompt and proper reporting.

The national Wagner Act, and the little Wagner Act of the states brings the place of the intern as an employee to the serious consideration of hospital authorities. Intern's councils, formed for scientific purposes for the maintenance of standards, should not be the cells for labor agitation.

It is unfortunate that social legislation compels the hospital to place the intern in the category of employees. "An employee is one whose duties consist in the rendition of prescribed services and not the accomplishment of specific objects, and whose services are continuous, not occasional or temporary."

For compensation purposes the intern is covered by the law governing employees. Interns and nurses in a hospital maintained by municipal or other political units are also within the compensation law coverage. In a case of voluntary insurance by a charitable trust an intern is also held to be an employee. An intern in the Cook County Hospital contracted epidemic meningitis and died. An award to his widow by the arbitrator was set aside by the industrial commission but it was affirmed by the circuit court and by the Supreme Court of Illinois. When the Social Security Act is extended to include hospitals the house officer will doubtless be included in its coverage.

No general doctrine exists fixing the limits of responsibility of different types of hospitals and the different classes of persons attached to the hospitals. Court decisions vary from state to state. House officers, along with pathologists, roentgenologists, as well as private physicians and special duty nurses are classed as non-administrative employees. The general rule is that the hospital is not liable for their negligence. Administrative employees, all those attached to the superintendent's office, for instance, form the other group. Responsibility for their conduct may rest upon the hospital, a knotty problem which the courts have considered for years.

Ever since 1846 when the theory of absolute immunity of the charitable institution resting on its "trust funds" was announciated, down to the present time many court decisions have been handed down. Some states have accepted decisions of the New York State courts in large part. Confusion has resulted, largely because there has been no movement by those most interested to clarify matters by legislative enactment.

"Instability of economic conditions, especially within the last ten years, has greatly altered, and visibly changed the mental reactions of the average individual within our community. Particularly in the larger population centers, the older, confidential and trusted relationship between the physician and his patient has given way to habits of

medical shopping. There has been an increasing tendency to seek legal redress through malpractice claims."

No uniform policy for limited licensure or exemption of interns from provisions of the law exist in the various state enactments. Thirty-six states practically ignore the medical student and the intern. Sixteen states have statutory provision, most of them being exceptions to the application of the medical practice act. In a few states, the intern and/or the medical student is affirmatively permitted to practice medicine in a hospital under the guidance of teachers. Apparently, Massachusetts alone, grants "limited registration" for the definite period of his internship, upon completion of three and one-half years of medical study in approved schools. Limitations are placed on the activities of such students, and the hospital and the other institutions to which they are attached under the direction of staff members. For the period of his limited registration the intern is permitted to sign birth and death certificates.

New Hampshire permits "resident physicians" to practice in any legally incorporated hospital. This is not wholly satisfactory since no report of appointment is required of the "resident" or the hospital. Supervision cannot be exercised by the board of registration. Physicians ineligible for registration may become, for an indefinite period, whole time members of the staff of such institutions as the state tuberculosis sanatorium, or the hospital for mental diseases, without compliance with the medical act. A lenient attitude is shown interns apparently by boards of registration out of consideration for the financial position of these young men, many of whom do not intend to locate in the state. All of them are known to be under the supervision of mature staff members, who with the hospital are presumed to be responsible for the conduct of house officers.

But should the intern as an unlicensed physician be charged with malpractice he is indeed vulnerable, and his defense is handicapped. The attorney for the plaintiff emphasizes the illegality of his action. In addition to the charge of professional misconduct he is charged with crime. In some instances where the hospital has been freed of the charge of negligence the intern himself has been charged with the same offense.

It is a fact that some hospitals are understaffed and interns, some routine administrative work being essential, may be hurried or become careless, or because of fatigue make the fatal slip in technic or the thoughtless remark that leads to trouble. Sufficient oversight by the staff and relief from some routine will prevent such errors. To the ward patient the intern is the patient's doctor, coming closer, by far, to the man or woman than the chief visiting surgeon. We cannot forget that.

It may be argued that the chances for malpractice suits involving the intern are rare. But the slight yet perceptible increase in this sort of litigation, and the eagerness of attorneys for business does not increase safety of the intern. Such cases, like many others taken on a contingent fee basis, possess a nuisance value at least. Some settlement, however small, must be made, or one must face the alternative of expensive litigation. Attention should be directed to the evolution of some scheme for protection of the intern from attack.

Tuberculosis and Appendicitis — Eight more cases of tuberculous appendicitis were added recently to the report of the 151 already in the literature prior to May, 1937. The clinical course of the disease tends to chronicity, with recurrent attacks usually milder than the pyogenic types of appendicitis. Earlier recognition and early operation are urged. Card, T. A., Cal. West. Med., 1939, 50.

Tuberculosis is Mass Murder—It would cost this country a hundred times less money to wipe out tuberculosis in one generation than to maintain this ghastly luxury for an indefinite period, according to Paul de Kruif.

*Poor Patients in Hospital Wards**

By Sister Ricard, St. Mary's General Hospital, Lewiston, Maine

Before replying to the very kind invitation of Doctor Hiebert, the distinguished President of the Maine Hospital Association, I confess I felt bound to hesitate about accepting it from fear lest this might be inconsistent with the customs of our Religious Order. However, after reflection and consultation, I have thought I ought to accept in the hope of making, even to such a body as this, some modest suggestions on a subject close to my heart, one which may be said to explain the existence of my dear Community, the Sisters of Charity. I wish to speak to you of the need of making best possible provision for the invalid poor.

Even if, in a hospital, it is our duty to show love and care of invalids of every sort, it seems to me we are bound to pay particular attention to the poor patients in our hospital wards. Poor patients, whoever they may be, are usually more or less distressed and ill at ease in an environment which is wholly strange to them and involves contact with those who are entire strangers. Moreover, those with sensitive natures find it hard to be surrounded by neighbors who differ from them in education and social position. Often too, the way in which they have heard people speak of hospital wards has been unfavorable; they are filled with prejudices, which only the best of care, kindness, and personal devotion can dispel. It is, therefore, of great importance to inspire them with feelings of confidence and security from the moment of their arrival. First impressions largely determine the amount of good the hospital may do them. On the one hand, these may make the patient confident, hopeful, and ready to submit willingly to everything required, or, on the other, to make him restless and suspicious, and so likely to show unfavorable physical reactions.

It is a great mistake to let a poor patient suspect that he is only a "case" rather than a person, that as a "case" he may be possibly of more or less interest, but that as an individual, suffering perhaps more in spirit than in body, he is only to be ignored. Once installed in the hospital ward, he will probably find more comfort and care than he could have anywhere else; yet it is also highly important that doctors and nurses show such an interest in the patient personally as to give him a conviction that they will do all in their power to ensure him best chances of recovery.

Several years ago, a newspaper-writer published an article on "Beauty in the Hospital". With full appreciation of this work of his, I wish he might be inspired to write another on "Kindness and Personal Sympathy in the Hospital." We are all in sympathy with this writer's plea for Beauty in the surroundings of our patients. We wish to provide them not only with comforts, but also with luxuries. We know the value, as an aid to their convalescence, of having all their surroundings restful and attractive. Beauty is good, Ugliness an evil. Yet surroundings need not be ugly, even if they have to be very simple and very plain; and there is one form of beauty, a necessity which ranks as one of the highest luxuries, at which all of us who have care of the sick must constantly aim. That is the necessity and luxury of cleanliness. Nothing conduces more to the welfare of our patients than that everything about them, their bodies, their beds, their wards, should be kept as nearly spotless as possible. There are few places where this is more difficult than in a hospital ward. It can only be had at cost of constant watchfulness and constant hard work; but we can often pay prices in hard work for things which we could not secure by paying prices in money. One thing which we who have care of the sick can spare no pains to secure is that neatness and orderliness, which counts for so much in comfort, convalescence, and cures. This is one of the chief forms of beauty and luxury that we can give them. Especially do our poor patients need this.

* Read before the 1938 Annual Meeting of the Maine Hospital Association held at Lakewood, August 31, 1938.

Oftentimes we try to establish for them stricter standards of cleanliness than they have ever established for themselves; often they find some of our requirements irksome; but, in the long run, nothing counts for more in their physical welfare or is more appreciated. If they come from homes filled with dirt and disorder, or from no homes at all, all the more must we try to provide that cleanliness which is next to godliness in our hospital wards. Among the highest beauties of the hospital are clean bodies, clean beds and clean floors.

But when all has been said of the desirableness of Beauty, there is a greater desirableness in Kindness and Sympathy, and this not least in regard to our poor patients. Far better than pictures of the great masters, then flowers and luxurious appointments arranged with taste, will we find for promotion of the welfare of our patients the understanding spirit of true charity. That is the ideal for us all to follow in obedience to a universal law affecting all creation from lowest to highest, that all lesser things must be so used as to secure the greatest good of all. "If I should distribute all my goods to feed the poor, and if I should deliver my body to be burned, and have not charity, it profiteth me nothing."

Every sick person, as we all know, becomes in some degree a child, a human being in need of support, protection, and help, almost unconsciously self-abandoned to the disinterested love of some other person. In a word, he wishes and wills to be protected. He longs for compassion which his spirit hopes to find in the twofold power of others to understand and to soothe and soften him. The poor patient makes special claims on our sympathy. Removed from his ordinary surroundings and course of life, he is especially liable to be seized with melancholy. His personal cares, worries and needs, probably increased by enforced inaction, become obsessions. Many who have taken pride in their health, as others feel vanity over good fortune, experience in times of weakness a sort of humiliation which irritates them. It is necessary for the nurses to grudge no time or trouble, for the doctor wisely to detect this sort of distress, that they may bring the necessary solace. Confronted by kindness, the greatest sufferer forgets pain, the most discouraged recovers hope, the worst grumbler becomes fairly good-natured. Even the insensibility of a woodman may be vanquished. One incident among a thousand that might be cited, will illustrate what I am saying.

To one of our hospitals, sometime during the past two years, came a man whose occupation was that of a trapper. He was suffering terribly from pains in the stomach apparently caused by ulcers. An operation was performed with utmost care by one of the house-surgeons, only to disclose that the disease was fatal. The nurses, although knowing the case hopeless, showed every interest and care, despite the fact that to all their kindness the sick man only responded by bursts of anger, sometimes even by curses. The doctor, though ready to do all in his power, thought best to make his visits infrequent to avoid the man's tiresome and useless complaints. The trapper noticed this, thought himself neglected and assailed one of the nurses: "I know that the doctor is ashamed of the bad job he has made with me; that is the reason he keeps away." The nurse tried to reassure him, and spoke tactfully of the doctor's regret he could not effect a cure, a fact not before told the patient for fear of making him worse. The man was at last convinced that he had not been neglected, and that doctors and nurses were doing all in their power to secure his comfort. The nurse's sympathetic words at last made their impression. There was a sudden change; the man became more trustful; he who at his arrival had shown himself such a rebel, became responsive and resigned, and so continued until the moment of death. The kindness and patience of doctor and nurses had helped him to gain a self-control which brought a sort of eternal serenity, which, we may hope, he still enjoys.

Too many people have prejudices against the hospital, which, on all accounts, must be made to disappear. The hospital must prove its usefulness, its necessity, its benevolence, by becoming day by day a more effective instrument for restoration of health, moral as well as physical. Poor as well as rich must have no fear of our institutions, nor dread being taken to them for treatment. All those

who have been cared for by us should return to their homes with their feelings of joy mingled with regret at leaving us, and with a disposition to come back to us, should circumstances compel. Moreover, it is necessary to interest people in general in our hospital. It is not always their fault if they show no interest; they do not know the difficulties of our practical problems, nor the facts concerning our costs of maintenance, and of all the benefits which they secure. It is good work to keep them informed.

I beg permission to express a hope that this meeting will give special thought to that charity which makes us regard the poor man as a friend, better still, as a brother. For we as Sisters of Charity, besides financial responsibilities often very hard to carry, like to remind ourselves that we are enlisted in the great work which Christ undertook toward those whom He regarded as a flock, of which He Himself is the Good Shepherd. And this flock, looking upon us as consecrated to the service of God, may rest assured that all interests are understood when it falls to our lot to ease bodily suffering and to show sympathy with any member of that great human family of which we ourselves form part. Every grief touches us; every groan lies within our own kingdom; every form of suffering within our proper domain.

To keep ourselves up to the height of our task, we may count upon the help of Providence and upon the aid of friends and benefactors, as well as—which goes without saying—upon the skilled guidance and support of the doctors. In St. Mary's Hospital this guidance and support never fails us. These gentlemen, be it said in their praise, have worked unceasingly in loyal coöperation with us, giving us the inspiration of their own high ideal and having no goal in sight but that of the common good.

Acta Radiologica, Stockholm*

19: 409-504 (Nov. 30) 1938

*X-Ray Diagnosis of Intestinal Obstruction. A. Hoyer.—p. 409.
Dosage, Duration of Treatment and Reactions in Protracted-Fractional Roentgen Treatment, with Special Reference to Carcinoma of the Upper Air Passages. J. Juul.—p. 433.
Cancer of the Penis and Its Treatment. C. J. Hansson.—p. 443.
Peptic Ulcer of the Esophagus. F. Norgaard.—p. 458.
Fundamental Property of Planigraphic Image-Formation. R. H. De Waard.—p. 465.
Gastric Syphilis: Two Cases. P. A. Blinkenberg.—p. 480.
Notes on Myeloma. J. Bichel and P. Kirketerp.—p. 487.

X-Ray Diagnosis of Intestinal Obstruction

Hoyer points out that it may be difficult to make the clinical diagnosis of intestinal obstruction in the first twenty-four hours because of the fact that the symptoms typical of this lesion may be totally or partly absent. The pain generally gives rather indefinite data on which to base the diagnosis, as it is indistinguishable from colicky pain of other causes and it has no typical location. Neither does the vomit supply information before the vomitous becomes foul. This is a late symptom, however, and indicates that the situation is becoming exceedingly grave. Information to the effect that there has been no passage of feces or flatus is of small value during the first twenty-four hours. The signs also are scarce during the first twenty-four hours. In view of these difficulties encountered by the clinical diagnosis it was of great importance that Kloiber in 1919 discovered that the x-ray diagnosis of intestinal obstruction could be made with great certainty at an early point of time, without contrast mediums, only by x-ray examination with *horizontal direction of the rays*. In this manner he revealed the characteristic fluid levels caused by the simultaneous presence in the intestine of gas and thin intestinal contents. After reviewing Kloiber's experience with roentgenoscopy in

Continued on page 142

* Reprinted from *The Journal of the American Medical Association*, February 4, 1939.

Meeting of the New England Oto-Laryngological Society, November 15, 1938, at Boston, Massachusetts

By Werner Mueller, M. D., Boston, Massachusetts, Abstract Editor

A Case of Cardiospasm with Autopsy Report. Dr. Harry Butler, Bangor, Maine.

A female, aged 29 years, with a history of cardiospasm, was referred to the author from the Medical Service. Medical examination and Roentgen studies had failed to show any cause for regurgitation of food over a period of 2 years other than fibrosis of the lower end of the esophagus. The esophagoscopic picture was typical of "cardiospasm."

Treatment by bouginage was carried out at various times, but with only temporary improvement. After the first attempt at dilatation the patient complained of sub-sternal pain, but showed a normal temperature, pulse, respiration, and blood count. After bougies and esophagoscopes had been passed several times, the Tucker dilator was resorted to. A pressure of 5 pounds was used the first time. The patient did well, gaining 20 pounds during the following 2 months. During this period an afebrile upper left lobe inflammation appeared, but cleared up by spontaneous absorption. Before discharging the patient, the Tucker dilator was used once more, this time at a pressure of 8.5 pounds. On the same evening the sub-sternal pain reappeared. Within 36 hours the temperature rose from normal to 103 degrees, the W. B. C. rose to 10,200 and later to 18,000. On the fourth post-operative day the roentgenologist reported a shadow suggestive of sub-diaphragmatic abscess. An abscess of the lesser omental cavity was evacuated. Two days after this the patient died of peritonitis. Autopsy revealed a perforation on the posterior wall of the stomach, about 2 inches below the cardiac orifice. Another small area was nearly perforated. A diagnosis was made of spontaneous rupture of the stomach due to a weakening of the stomach wall by a previously existing pathological condition. The author believes that the latter contributed to the development of the "cardiospasm."

Discussion: Dr. Mosher felt that 8 pounds pressure was *too much*. He has found that strictures do not require such high pressure.

Post-Operative Tonsil Hemorrhage. Dr. John R. Noyes, Brockton, Mass.

After reviewing the various hemostatic procedures of the past and present the author describes a method that has yielded him excellent results in 126 cases during the past 18 years. After cleaning out the tonsillar fossa and locating the bleeding point, 1-2 cc. of a one percent novocain solution, containing one minim of adrenalin in each cc. of novocain, are injected around it. If the bleeding point cannot be found it is best to inject various areas. Up to 10 cc. of solution can safely be used. The author believes that the mechanism of the hemostasis under this treatment is the pressure exerted by the injected fluid plus the vaso-constrictor action of the adrenalin.

Discussion: Dr. George L. Tobey cited a case of bleeding into the tissues of the soft palate. All procedures to stop the hemorrhage had failed. At the time of this discussion he considered the necessity of having to tie the external carotid artery.

Dr. August L. Beck prefers to place his trust in the bi-polar diathermy apparatus. Dr. Lyman G. Richards laments the fact that so little is known about the cause of post-operative bleeding from the tonsillar fossa. He had found the bleeding and clotting time to be of no help at all. Primary hemorrhage can be the fault of the operator, secondary bleeding not.

Precautionary Measures in Paranasal Surgery Under Local Anesthesia. Dr. W. H. Chaffers, Lewiston, Maine.

The author cites the case of a young physician who was twice treated for an obscure painful eye condition. Routine examination

revealed a sensile "tumor" on the border and lateral surface of the right inferior turbinate. This proved to be a calcium encrusted cotton tampon. Finally it was learned that 9 years previously the patient had been operated upon for a dentigerous cyst of the maxilla and that cotton tampons had been placed into the nostril of that side. One of these had been overlooked and it remained in the nose, giving rise to coryza-like symptoms and slight respiratory obstruction. Some years previously the author, while doing a secondary Caldwell-Luc operation, removed a cotton tampon from the antrum. This tampon probably necessitated the secondary operation by interfering with healing.

The author stresses the importance of thoroughness in history taking regardless of whether the patient be layman or physician. He also considers it advisable to institute tampon counts just as the general surgeon insists on sponge counts.

Applied Biochemistry in the Etiology and Treatment of Clinical Conditions of the Nasal Accessory Sinuses. Dr. D. C. Jarvis, Barre, Vt.

The author believes that in many cases certain foodstuffs can give rise to nose and throat conditions with which every nose and throat specialist is confronted daily: excessive watery or muco-purulent nasal secretion, enlarged turbinates, and a pharynx with large lateral bands and lymph follicles. These conditions are, in the author's opinion, due to what he terms "a block in the body process of cell oxidation." The offending foodstuffs the author has found to be wheat, graham, and buckwheat flour, white and brown sugar, and citric acid as found in citrous fruits. For these rye flour, oatmeal, cornmeal, honey, bananas and apple juice are substituted. For the most efficient utilization of these foodstuffs in the body cells it is necessary to supply oxidizing minerals, such as iodine, iron, copper, manganese, and arsenic, all in organic form. The mineral content of the blood determines the rate at which the blood sugar is burned. In the author's opinion the American diet is very low in mineral ash. The treatment of such conditions brought about by a "block in the body process of cell oxidation" is directed first to the establishment of a proper diet, second to the administration of an oxidizing catalyst in the form of insulin. Of this latter the patient is given 3 unit doses subcutaneously whenever he presents himself for examination. In addition the patient is instructed to take 3 drops of Amend's iodine solution 20 minutes before meals. Under this form of treatment cases of acute sinusitis usually clear up in 3 days, subacute cases require 10 days, and chronic cases 6-12 months. The author cited two typical cases which responded promptly under the treatment described.

Discussion: This paper was discussed by Drs. Goodell, Meltzer, Mosher, Seaver, and Berry, who expressed their appreciation of Dr. Jarvis' work and believe with him that there is a great deal in bio-chemistry that is worth considering in the work of the oto-laryngologist.

Hearing Aids — By a Wearer of One. Miss Elsie L. Staples, Executive Secretary, Boston Guild for the Hard of Hearing.

The speaker discussed the use of hearing aids from the standpoint of the wearer. She strongly advised that hearing aids be resorted to before the deafness had progressed too far. Most persons receive but little help from a hearing aid until the hearing loss amounts to from 30-35 percent, but when that point has been reached no further delay should be tolerated. No otologist should allow his deaf patients to struggle along until they have stopped trying to hear. At this point the speaker related how not one of the otologists whom she had consulted for the possible treatment of her deafness had called her attention to the use of lip reading or a hearing aid. It was her oculist who did that. The somewhat complex psychology of the deaf was discussed in some detail. Thus it makes a great deal of difference whether or not a deaf person hesitates to ask for the repetition of sentences or phrases. Some want to carry on their wonted activities, other resign themselves to be more or less cut off from the rest of their fellow beings.

The various forms, electric or non-electric, of hearing aids were described and discussed.

One fact must be borne in mind: there is no "best" hearing aid. Not only must the type and degree of the deafness be considered, but many other factors come into play to make a hearing aid useful to one patient and useless to another. A properly fitted hearing aid must not only increase the power of the sounds transmitted, it must also avoid distortion and adventitious noises. Clarity is just as important as loudness. The need for fighting unethical advertising on the part of manufacturers and dealers is obvious, for the deaf have always been a ready prey for those who promise them relief. The Boston Better Business Bureau has recently taken action to stop such advertising. Although hearing aids can restore the deaf to useful, happy individuals, it must be remembered that they have definite limitations. They do not raise the hearing level to anywhere near the normal points. Lip reading must always be ready to do its share in filling in the gaps left by the hearing aid, especially in the transmission of consonants. Finally, the speaker reminded the audience of the services rendered by the Boston Guild for the Hard of Hearing as a "clearing house" on all phases of deafness.

Discussion: The paper was discussed by Drs. Mosher, MacCready, Hill, and Tobey, as being one of the pleasantest on this subject ever given and clearing up a great many points as to the uses of hearing aids.

Surgical Technique for the Conservation of the Hearing in Chronic Mastoiditis. Dr. J. Morrisset Smith, New York City. By Invitation. This paper appeared in full in *The Laryngoscope* for July, 1938.

The author believes that it is impossible to deal with all cases of chronic mastoid infection by the use of one type of operation. The degree of necrosis encountered in the different cases should determine the surgical technique employed. Four types of procedure are recommended.

The complete simple mastoid operation is indicated where the removal of the drum and ossicles is not necessary. It consists essentially of the usual simple mastoidectomy plus a wide exposure of the attic by dissection of the bone at the root of the zygoma. The middle ear is cleaned of polypi or granulations through the external canal. The after treatment consists of cleansing irrigations from the mastoid wound as well as from the canal. This technique, which is especially indicated in young children, will frequently result in a dry ear with the preservation of valuable hearing.

The second technique differs from the first in that the incus is removed in order to facilitate the removal of granulations from the attic. The author claims that the removal of the incus has remarkably little effect upon the hearing.

In cases where the hearing in the other ear has been lost, or in the presence of an extensive bilateral infection where the preservation of the hearing may be vitally important, the third technique is employed. This the author calls the "new radical operation." It is devised to care for some of the cases requiring removal of the malleus and the incus without, however, necessitating the complete radical operation. The technique is as in the second type except for the removal of the malleus as well as the incus and the remaining portions of the drum membrane. The external canal and its lining are left intact. The after treatment includes irrigations and careful drainage. In the author's opinion this operation will be successful in many cases in which formerly the complete radical operation would have been used.

The complete radical operation is resorted to in complicated cases or where one of the above procedures has failed to check the progress of the disease. Ossiculectomy is not advised since it leaves the operator as well as the patient in the dark concerning the extent of the necrosis beyond the attic.

Editorial

The Annual Session

Today, more than ever before, in the face of the many rapidly changing conditions governing the practice of medicine, science progressing so rapidly that even workers in highly specialized fields regard frequent reviews and conferences as obligatory do our National and State meetings become more essential. The problems that confront us, economic and scientific, are increasing. A former president of the Maine Medical Association feels that organized medicine is on the defensive and must meet the challenge of the widespread and often unfair propaganda directed against it by those with far from selfish interests.

Many things that we know to be without justification are causes of concern and bewilderment to the public we serve. The media of platform, press and radio must be utilized to keep the public informed of matters pertaining to their health and safety.

Each County Society has one or more members in the House of Delegates. If mandates can be issued to the profession of the State they must come through the general assembly of your delegate body, It, and it alone, is responsible for the pronouncements it lays down and the assignment of duties to those holding official positions. The definite problems of each County Society varies many times from those of its neighbors; they become, and are our general concern.

The official program, carried in the present issue, merits sincere appreciation of the work of the Scientific Committee and offers much in the way of opportunity for the discussion of problems of interest and importance. Most fortunate are we in having as our speaker at the annual Banquet, the editor of the *Journal of the American Medical Association;* Dr. Morris Fishbein. The threat of "socialized medicine", dictated by and from Washington, cannot be dismissed as an idle threat and something that cannot happen here. It can and it HAS, and no one is more capable of presenting its fallacies, dangers and injustice than our distinguished guest. Not only is he conversant with the facts but is most competent to advise the ways and means to avert further encroachments and bureaucratic control.

Not only do our annual sessions offer renewed opportunities for needed accomplishments and the discussions of problems of great importance to every practitioner of medicine but they also afford a most necessary recreational diversion. As has been stated before—the financial burden on the State Association is materially lessened by the exhibitors who have become no minor part of our meetings. From an educational standpoint these exhibits are most important. They bring before us the advances rapidly being made and competent men are available to show and discuss the merits of their products of necessity in our daily work. As an appreciation of their being with us can only be shown by attendance at the exhibits—let us manifest it collectively and personally.

To the delegates from our sister States, a most hearty and fraternal greeting is extended. To our own members and visiting friends our sincere thanks for the excellent program provided.

WILLARD H. BUNKER, M. D., F. A. G. S.

President Maine Medical Association, 1938 - 1939

The President's Page

To the Members of the Maine Medical Association:

Now that the time has finally arrived for me to write my last President's Page and sever my connections with an organization with which I have been closely associated for several years, I find it difficult to express my gratitude to the officers of our Association for their friendly coöperation and willingness to assist me during my year as President.

An equal amount of gratitude goes to the individual members of the different committees and last, but by no means least, I wish to pay a tribute to our Assistant Secretary, Mrs. Esther Kennard, for her efficient service during the year.

As President, I have had my share of difficulties which could in no way be avoided, but these have been overshadowed by many pleasant occasions.

Certainly any President of this Association who retires from office with the Dove of Peace still resting on his shoulder is entitled to very little credit.

Without appearing presumptious I can truthfully say that we have had a very satisfactory year.

We have upheld the rights of our State Association and with the excellent coöperation of the different State Organizations closely allied with us have passed through a legislative year unharmed.

I feel confident that the affairs of our Society can safely be entrusted to my successor, George L. Pratt, M. D., because of my personal acquaintance with him and my knowledge of his excellent qualities of fairness and determination.

Therefore, in closing, I can do no better than to wish him all possible success in his undertaking and to every member of our Association, I extend my thanks for their friendship and support during the year.

Willard H. Bunker, M. D.,
President, Maine Medical Association.

Graduate Education

Commonwealth Fund Postgraduate Medical Fellowships

The Commonwealth Fund of New York City is making available fellowships in the subjects indicated below to members of the Maine Medical Society, to be given at Harvard Medical School, Courses for Graduates, 25 Shattuck Street, Boston, Massachusetts.

Medicine, given at the Massachusetts General Hospital, Peter Bent Brigham Hospital or Boston City Hospital. A group of at least six must take the course at one time. Such a group may be made up from any or all of the four states in which the fellowships are offered; namely, Maine, New Hampshire, Vermont or Massachusetts.

Pediatrics, given at the Children's Hospital. Not more than six may take the course at one time.

Obstetrics, given at the Boston Lying-In Hospital. Not more than six may take the course at one time.

Office Surgery, given at the Boston City Hospital; designed for physicians engaged in general practice; subjects studied are surgical problems met in the office; instruction in the out-patient department. A group of at least eight must take the course at one time.

Fellowships are for one month. Preference will be given those who take the course in medicine, for a second month in medicine or in obstetrics, pediatrics or office surgery, when fellowships are available during succeeding years. The stipend is $250.00 plus tuition and actual travelling expenses.

Qualifications: Applicant must be a graduate of a grade "A" medical school; a member of the Maine Medical Society in good standing; must have been in practice at least five years and should preferably be under forty-five years of age; and must be a resident of a community of less than 10,000 population. Application blanks may be obtained from the Division of Public Health, the Commonwealth Fund, 41 East 57th Street, New York City, or from the Secretary of the State Medical Society.

The Bingham Associates Fund

The Bingham Associates Fund is offering the following courses, in addition to the one-month course in General Medicine.

Obstetrics and Gynecology—1 Month.

This work will be conducted under the control of the Faculty of Tufts College Medical School. The facilities of the New England Medical Center, the Joseph H. Pratt Diagnostic Hospital, The Boston Dispensary and the Evangeline Booth Maternity Hospital will be utilized.

Pediatrics—1 Month.

Four courses are offered; during the months of November, 1939, January, February and March, 1940. A maximum of four men can be accommodated in each course. This work will be conducted under the control of the Department of Pediatrics, Tufts College Medical School, and the entire facilities of the Department will be utilized insofar as may be feasible. These consist of the following institutions:

The Children's Department of the Boston Dispensary, where ambulatory patients are available.

The Boston Floating Hospital, where bed patients from birth to twelve years are admitted with all types of diseases, except contagion.

The Evangeline Booth Maternity Hospital, utilized to demonstrate diseases of and care of the newborn.

The South Department of the Boston City Hospital.

The Charles V. Chapin Hospital, Providence, Rhode Island (both available for the study of contagious diseases).

The New England Deaconess Hospital, where a large group of diabetic children are under supervision and care.

Allergy—40 Hours.

Courses will be given on receipt of at least six applications.

The course is designed to familiarize the general practitioner with the recent advances in the field and give him training in the newer laboratory procedures. Preparation of allergens and the latest development in testing will be taken up. The mornings will be devoted to the didactic lectures and work in the clinics. The afternoons will be utilized for laboratory training.

Hematology—40 Hours.

Courses will be given on receipt of at least six applications.

The course is designed to acquaint the general practitioner with the recent practical advances in the field of blood diseases. The mornings will be devoted to conferences and laboratory training, the afternoons to didactic lectures on the blood dyscrasias and their treatment.

Proctology—40 Hours.

Courses will be given on receipt of at least six applications.

Utilizing the out-patient clinics in the Boston Dispensary, the Massachusetts General Hospital, the Cambridge Hospital and the Newton Hospital. Study of the anatomy, physiology and pathology of the anus, rectum and colon, correlated with the history, examination, diagnosis and treatment of such conditions will be given. Lectures will be illustrated by lantern slides. It is preferable that the enrollment be limited to four students during any one week.

In addition to the above courses the list which follows indicates the subjects in which courses are available or in preparation for presentation in the near future:

Diabetes
Endocrinology
Electrocardiography
Cardiology
Genito-urinary diseases
Diseases of the chest
Gastro-enterology
Dermatology

Fellowships covering these courses are available to members of the Maine Medical Association. Each one-month Fellowship carries an honorarium of $250.00. Rooms and meals are available for Fellows at reduced rates, in the New England Medical Center. Each one-week Fellowship carries an honorarium sufficient for expenses.

Application for Fellowships should be made to Samuel Proger, M. D., 25 Bennet Street, Boston, Mass.

Further information regarding opportunities for Graduate Education may be obtained from the Committee on Graduate Education.

Frederick T. Hill, M. D., Waterville.
Julius Gottlieb, M. D., Lewiston.
Norman H. Nickerson, M. D., Greenville.
Frank H. Jackson, M. D., Houlton.
Eugene E. Holt, M. D., Portland.

Report of the Necrologist, 1938-1939

Maine Medical Association deceased members since June, 1938:

Abbott, Edville Gerhardt, Portland
Badger, Forrest Hartley, Winthrop
Bragdon, Frederick Augustus, Springvale
Cummings, Edson S., Portland
Elliott, Gilbert M., Brunswick
Foss, Clarence W. P., Brunswick
Goodwin, Harold Merle, Bangor
Hanlon, Orville Leon, Mexico
Marshall, Sumner Bradbury, Alfred
Moulton, Willis Bryant, Portland
Plumer, Herbert Hall, Union
Powell, Lester Lovett, Portland
Randall, Jesse A., Old Orchard Beach
Simons, Ralph D., Gardiner
Trefethen, William J., Wilton
Weeks, George W., Cornish
Woodman, Daniel Nash, North Haven

Respectfully submitted,

Frederick R. Carter,
Necrologist.

Report of the Secretary-Treasurer

As Secretary, I am pleased to submit the following annual report:

There are 691 active members in good standing in the Association, and 25 honorary. We have added to our roster 41 new members and have lost 17 through death

In accordance with our By-Laws, Chapter VIII, Section I, we dropped, in April, 16 members for non-payment of dues. Three have been reinstated.

In accordance with a vote of the Council, that the unexpended income from the Thayer Library Fund be used to purchase books for the Spalding Memorial Library at the Maine General Hospital, Portland, the following books have been purchased at a cost of $101.80 and presented to the Library:

Davis Gynecology and Obstetrics
Cabot's Urology
Boyd's Textbook of Pathology
Bethea Materia Medica
The Technic of Medication
Forkner's Leukemia and Allied Disorders
Key and Conwell Fractures
Year Book of Obstetrics and Gynecology
Fillers for Brenneman's Pediatrics

At the request of the Legislative Committee the Council authorized the President and Secretary to guaranty Mr. Locke, Attorney, the funds necessary to cover matters of interest to the Medical Profession at the 1939 Legislative Session. The Association has, therefore, paid Mr. Locke, for services and incidental expenses, a total of $1,034.92.

The 1938 fall clinical session was held in Lewiston, November 3rd and 4th. Interesting and instructive programs were presented by the Central Maine General Hospital and the Saint Mary's General Hospital.

The 87th annual session will be held at the Poland Spring House, June 25th, 26th, and 27th. The report of the Council for the year will be presented by the Chairman, Dr. Thomas A. Foster, at the first meeting of the House of Delegates, Sunday, June 25th, at 4.30 P. M.

The Association will have the privilege of presenting Fifty-Year Service Medals to Drs. Charles B. Sylvester, Portland; Gustav A. Pudor, Portland; Bernard A. Bailey, Wiscasset; and Henry I. Durgin, South Eliot; at its annual session banquet, Tuesday evening, June 27th, at 7 o'clock. In view of the fact that Gilbert M. Elliott, who died April 1st, would have been eligible to receive a medal at this meeting, the Council has voted that the Association present Mrs. Elliott with Dr. Elliott's medal.

The reservations for Commercial Exhibits are the largest ever and I sincerely hope that every member will show his appreciation of their support by making it a special point to visit these exhibits.

Your secretary wishes to express his appreciation for the coöperation of the county secretaries, councilors and other officers of the Association in carrying on the work of the Association.

The books of the Association and JOURNAL were closed and audited as of May 31, 1939. The Auditor's Report will be found on Page 151.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary-Treasurer.

May 31, 1939.

Only Six Per Cent—Of 8,654 veterans of the World War hospitalized for tuberculosis in six months, 71% were far advanced, 23% moderately advanced and only 6% were minimal. MATSON, R. C., U. S. Vet. Ad. Phys. Conf., 1938.

Self-Protected—Few physicians die of tuberculosis despite the fact that they are constantly exposed to it. Knowledge defends them as it may yet defend other groups in the population when properly educated in self-protection.

Councilor Reports

Report of Councilor, First District

To the Officers and Members of the Maine Medical Association:

The Medical Societies of York and Cumberland Counties are active and well organized. The York County Society has a paid-up membership of forty-six and one honorary member. During the year three physicians were admitted to membership; Dr. W. L. Morse of Springvale, Dr. Kenneth Cuneo of Kennebunk, and Dr. Carl E. Richards of Alfred, and four members were lost by death: Dr. Frederick A. Bragdon of Springvale, Dr. Jesse A. Randall of Old Orchard, Dr. George Weeks of Cornish and Dr. Sumner B. Marshall of Alfred.

Quarterly meetings have been well attended, twenty-two being present at the last meeting in Kennebunk.

During the summer, York and Cumberland had a joint meeting at Long Island in Casco Bay. In the autumn the Society held a meeting in Sanford at the Henrietta D. Goodall Memorial Hospital, at which time Dr. Bragdon of Springvale received birthday greetings from the members. Dr. Bragdon informed and entertained the members of the Society with reminiscences of his colorful practice in York County, and the President, Dr. Bunker, addressed the meeting, emphasizing the advantages of sound organization, high standards of practice and ethics of consultations.

The Annual Meeting in January was held at The Normandie in Scarboro. Dr. Dana B. Mayo of Eliot was elected President; Dr. W. T. Roussin of Biddeford, Vice President; Dr. Charles Kinghorn of Kittery was re-elected to fill the position of Secretary, which he has filled so adequately for many years; Censors: Dr. S. A. Cobb, Sanford, Dr. Paul S. Hill, Jr., Saco, Dr. E. C. Cook, York; Delegates to State Society: Dr. C. W. Kinghorn, Dr. S. A. Cobb; Alternates: Dr. J. H. MacDonald, Kennebunk, Dr. W. H. Kelly, Sanford. A panel of Maine physicians under the Chairmanship of Dr. F. T. Hill of Waterville discussed "Pneumonia."

The Spring meeting was held at The Tavern in Kennebunk. Dr. Kinghorn and Dr. Carl Corson of Portland were the speakers, Dr. Kinghorn presenting some lantern slides of ear conditions and Dr. Corson speaking about "Fractures."

The Cumberland County Medical Society boasts a membership of 172 active members, and five honorary. Nine physicians have been admitted to membership and nine members have been lost by death. This Society has held five meetings including the Clam Bake at Long Island with the York County Society. At the October meeting, Dr. Roland Moore presented moving pictures of obstetrical procedures and discussed the problems involved. Dr. Bunker visited the Society and addressed the members with his usual vigour and straightforwardness.

At the Annual Meeting in December, Dr. George A. Tibbetts was elected President; Dr. E. H. Drake, Vice President; Dr. Harold V. Bickmore, Secretary; Dr. Henry M. Swift, Counselor for 3 years. Delegates: Dr. L. A. Brown, Dr. W. D. Anderson, Dr. J. C. Oram, Dr. F. A. Smith, Dr. Ralph A. Heifetz, Dr. D. H. Daniels. Dr. Maxwell MacDonald of Boston spoke on "Emotions and Bodily Changes."

On January 27th, the Society had the privilege of hearing our New England Trustee of the American Medical Society, Dr. Roger I. Lee, speak to them on "The Doctor's Dilemma When and If the Government Goes into the Practice of Medicine in a Big Way."

In March, a panel of Maine physicians under Chairmanship of Dr. E. E. Holt, Jr., discussed "Cardiovascular Disease."

The Society conducted clinics at the local hospitals before the evening meetings and the attendance at meetings and clinics indicates a lively interest in the activities of the Society.

Respectfully submitted,

Thomas A. Foster,
Councilor, First District.

Report of Councilor, Third District

Knox and Sagadahoc County Medical Societies have held the usual number of regular meetings during the year and have been very well attended. Many of the programs have been of the post-graduate type, bringing about much discussion, making them interesting and instructive.

The good-fellowship which exists throughout this district is 100% and helps to make the people feel that they receive adequate medical care at home. It is indeed gratifying to report that several of the members have taken advantage of post-graduate courses during the past year.

Respectfully submitted,

Wm. Ellingwood,
Councilor, Third District.

Report of Councilor, Fifth District

Fifth District—Washington and Hancock Counties. The year has been marked by progress toward a renewed interest in County Societies and better attendance.

The definite and uncompromising policies of the President of the Maine Medical Association have given members a faith in the potential value of organized medicine.

Uniting with Waldo County, three meetings were held under the direction of authoritative clinicians furnished by the Maine Medical Association through the Committee on Graduate Education. These panel discussions were valuable and satisfactory methods of diffusing knowledge and stimulating further study. Members of this district hope to see this plan in force next year. During the year, the Hancock County Medical Society has lost to North Adams, Massachusetts, Doctor Pliny Allen. Doctor Allen was a well-trained, liberally educated young man of the type most needed in Maine. Doctor MacDonald, Machias, has resigned from the State Department of Health and Welfare and returned to Machias.

Respectfully submitted,

R. Bliss, M. D.,
Councilor, Fifth District.

Report of Councilor, Sixth District

The three Societies have held their usual quota of meetings, some of which I was able to attend. Penobscot Society is to be complimented on its programs, and I was sorry I could not be present at all of them. The Society deserves much credit for bringing many outstanding out-of-State men here, so that we can hear their views on various medical and surgical problems.

Piscataquis Society also had some good meetings, the joint meeting at which they entertained the other Societies being outstanding. Doctor Aldrich's talk on burns was exceptional and I am very sorry more of our members could not have heard it.

Aroostook Society held the usual two meetings, which were well attended. I think it would be a step in the right direction if the Aroostook Society could see its way to hold at least four meetings a year, and judging from the interest shown in the 1938 meetings, I feel such a program could be carried out successfully.

Respectfully submitted,

P. L. B. Ebbett, M. D.,
Councilor, Sixth District.

County News and Notes

Cumberland

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, March 7th, at 8.15 P. M. Thirty-two members and two guests were present.

The papers of the evening dealt with *Gastro-Intestinal Disorders of Infancy* and were as follows:

Hypertrophic Pyloric Stenosis, by Dr. E. S. Lothrop; *Strictures of the Esophagus*, by Dr. G. O. Cummings; *Pylorospasm and Gastro-enterospasm*, by Dr. F. P. Webster; *Non-Obstructive Vomiting in Infancy*, by Dr. T. A. Foster.

Alice Whittier, *Secretary.*

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, April 4th, at 8.15 P. M. Thirty-one members and two guests were present.

Dr. E. Allan McLean was elected to membership.

The general scientific subject for the evening was *The Liver*. Speakers and their subjects were:

Physiology of the Liver and Diseases of the Liver, Dr. D. H. Daniels; *X-Ray Aspect of Diseases of the Biliary Tract*, Dr. L. T. Thaxter; *Pathology of the Liver*, Dr. Mortimer Warren; *Bio-Chemistry of the Bile*, Dr. W. D. Anderson; *Cholecystitis and Cholanzitis*, Dr. G. A. Tibbetts.

Alice Whittier, *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at the Veterans' Administration, Togus, Maine, on Thursday, May 18, 1939.

Clinical Session at 5.00 P. M., which was presided over by Leon D. Herring, M. D., President.

1—*Aortic Aneurism Simulating Pneumonia*, H. T. Perkins, M. D.; 2—*Glossopharyngeal Cyst*. H. A. Goalwin, M. D.; 3—*Massive Collapse of Lung*, Nathan Rosenberg, M. D.; 4—*Presentation of Urological Cases*, F. T. Williams, M. D.; 5—*Gastrojejuno Colic Fistula*. N. H. Badaines, M. D.; 6—*Some Studies in Bone Grafts*, J. E. Wheeler, M. D.; 7—Lantern Slide Demonstration of Certain Cardiac Abnormalities, M. T. Moorehead, M. D.; 8—*Streptococcic Pneumonia*, A. L. Fitzporter, M. D.

Dinner at 6.30 P. M., which was followed by a business meeting.

Minutes of the last meeting were read and approved.

Nathan Rosenberg, M. D., Togus, Maine, was elected to membership.

The guest speakers were Charles P. Shelton, M. D., Boston, Mass., Assistant Obstetrician, Boston Lying-In Hospital, whose subject was *Bleeding During Pregnancy*, and Joseph Shortell, M. D., Boston, Mass., whose subject was *Treatment of the Fractures of the Neck of the Femur*, which was illustrated by X-rays. Both papers were very interesting and were followed by a general discussion which brought out many points of interest.

There were thirty-eight members and guests present.

Respectfully submitted,

Frederick R. Carter, M. D.,
Secretary.

Knox

The scheduled meeting of the Knox County Medical Association was held at the Copper Kettle, Rockland, April 11, 1939. Minutes of last meeting were read and approved. Letters from Doctor Carter were read and discussed, as was also a letter from Doctor Webber of Lewiston concerning telephone rates and listing of physicians.

According to notice from the Maine Medical Association concerning the loss of membership for nonpayment of dues by April 1st, two members were declared dropped from the Association.

A discussion by Doctor Carswell of conditions at the Camden Hospital under present regulations, and the resignation of the nurses and physicians working there to become effective April 26, 1939, unless changes were made, was heard. Voted to endorse action taken by physicians.

Doctor Thannhauser of Boston, the guest speaker, gave a very brilliant and instructive talk on *Vitamin Deficiencies*. Much interest was evident, and practical points of treatment were stressed. Doctor Coombs of Waldoboro showed pictures of Vitamin C deficiency which were positive proof of a vitamin lack among certain groups.

Discussions by Doctors Foss, Soule and Brown were listened to with much interest.

A. J. Fuller, M. D.,
Secretary.

New Members

Androscoggin

Jean Bousquet, M. D., Lewiston.
S. E. Sawyer, M. D., Lewiston.

Kennebec

Nathan Rosenberg, M. D., Togus.

Notice

National Tuberculosis Association

The 35th annual meeting of the National Tuberculosis Association will be held in Boston, under the local chairmanship of Dr. Reginald Fitz, and which marks the first time that the association has met in New England in twenty-one years. The headquarters will be at the Hotel Statler, at which all meetings will be held, except the clinics which are indicated on the program. The dates of the meeting are from June 26-29 inclusive and six medical clinics have been planned, all of them on Wednesday afternoon, June 28, from 2 to 4.30. The clinics are open to all physicians attending the meeting but admission will be by ticket only. Reservations for the many and important interesting clinics can be made by writing to Dr. Frederick T. Lord, 305 Beacon Street, Boston. Dr. Lord will send interested physicians a program of the entire meeting and since the seating capacity of all of the amphitheaters is limited early application for tickets is suggested.

Necrology

Jesse A. Randall, M. D., 1863-1938

Doctor Jesse A. Randall died at his home at Old Orchard Beach, Maine, November 28, 1938. Born at South Limington, Maine, December 6, 1863, the son of Noah and Susan Huntress Randall, he was graduated from Bowdoin Medical College in the class of 1888.

Doctor Randall first set up practice in Newfield, Maine, where he remained for two years. He then went to South Waterboro for two years. In 1893, he came to Old Orchard Beach where he remained until his death. In his many years of service he was highly respected and deeply loved by all who had the good fortune to meet him. He was a member of both the York County Medical Society and the Maine Medical Association and served each to the fullest extent. In June, 1938, he was awarded a medal by the Maine Medical Association in recognition of his fifty years' faithful and unselfish service to the people of his community. His death leaves a deep sorrow in the hearts of men.

Continued from page 129

100 cases showing acute abdominal symptoms, the author describes and illustrates the x-ray symptoms of intestinal obstruction. When an occlusion takes place, the immediate result is an accumulation of thin intestinal contents in the oral direction, whereas anally to the occlusion the intestine is more or less completely emptied. There is increased peristalsis. The intestine makes every effort to pass the obstruction. Not infrequently patients with obstruction of the small intestine have spontaneous defecation shortly after the onset of the pain. Next comes an abnormal fermentative process of the intestinal contents with development of gas. This supplies conditions for the formation of fluid levels which, according to Kloiber, commences two or three hours after the onset of the attack. In mechanical ileus the fluid levels are usually visualized in two segments of the same coil at different heights. Fluoroscopic examination may demonstrate how the fluid levels rise and fall. This symptom is an important aid in the differential diagnosis between mechanical and paralytic ileus. In paralytic ileus the peristalsis has ceased and the fluid levels are stagnant. The coil of intestine lying immediately proximal to the obstruction, the so-called prestenotic coil, frequently presents a peculiar condition. The peristalsis here is particularly strong. The coil rises in the abdomen in the form of a reversed U. It has a stiff appearance. The tonus seems to be stronger than in the other dilated intestines. If an entire coil of the small intestine is shut off from the intestinal tract, both segments being strangulated, this coil becomes greatly dilated by gas and is easily recognizable in the roentgenogram. At the same time this supplies the accurate topical diagnosis, which is represented clinically by the "hypogastric football" (Wahl balloon symptom). The author further mentions a roentgenologic symptom which, in his opinion, is of great importance to the diagnosis. This is the more or less complete absence of gas from the large intestine in the presence of obstruction of the small intestine. The author says that at the surgical department of his hospital x-ray examination is now employed in all cases of suspected intestinal obstruction. The material available so far includes forty-six cases. In all cases the x-ray examination supplied a correct reply as to whether or not an intestinal obstruction was present. In a majority of cases the site of the lesion could be given. The mortality from intestinal obstruction has decreased considerably subsequent to the adoption as a routine method of the x-ray examination of abdominal cases in which intestinal obstruction is suspected.

PROGRAM

87th ANNUAL SESSION

MAINE MEDICAL ASSOCIATION

June 25, 26, 27, 1939

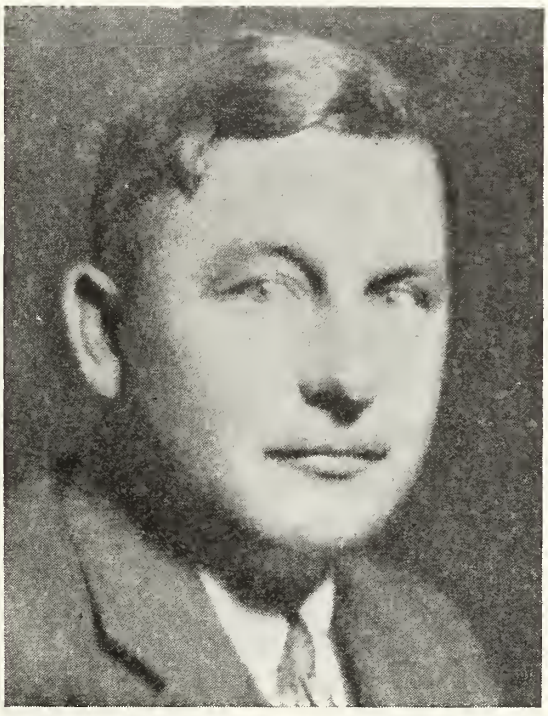
Poland Spring House

Poland Spring, Maine

PROGRAM ARRANGED

by the

SCIENTIFIC COMMITTEE

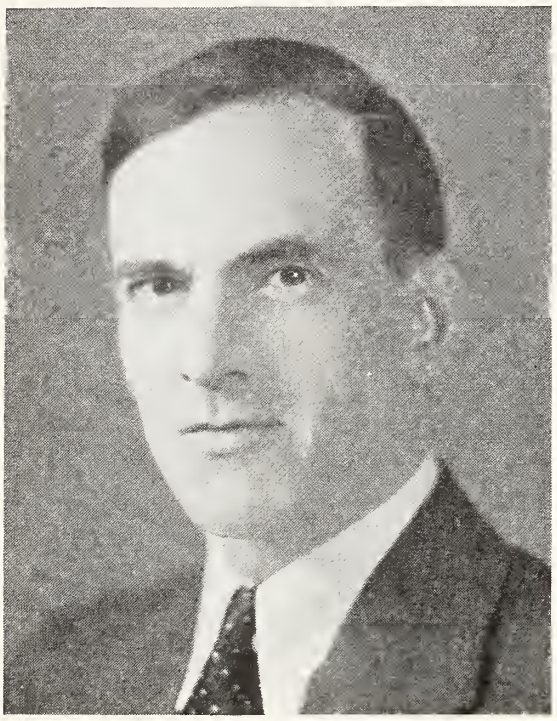


STEPHEN A. COBB

Chairman

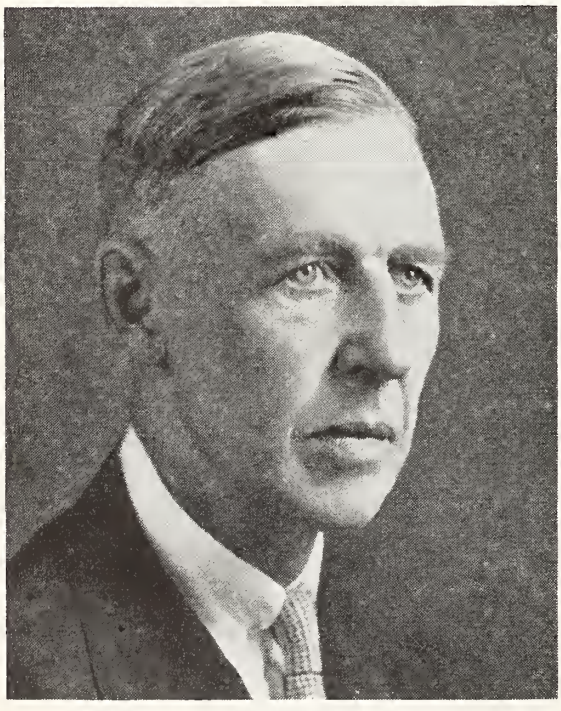
Members

SCIENTIFIC COMMITTEE



M. S. F. GREENE

H. G. SCRIBNER



MORTIMER WARREN

FREDERICK R. CARTER, Secretary

INFORMATION

Registration headquarters will be in the Lobby of the Poland Spring House. Every member and guest is requested to register promptly on arrival.

A telephone has been installed at the registration desk to facilitate the handling of emergency calls. All Emergency Calls should be referred to the registration desk. To insure prompt and efficient service physicians expecting emergency or urgent calls will please inform the attendants at this desk. (Telephone Number Poland 35.)

All papers read before this Association shall be its property, for publication in THE JOURNAL *of the Maine Medical Association, and when read shall be deposited with the Secretary.*

PROGRAM

SUNDAY, JUNE 25, 1939

4.30 P. M.

First Meeting of the House of Delegates.

8.30 P. M.

Entertainment for the Doctors and their wives, by a nationally known prestidigitator.

MONDAY, JUNE 26, 1939

Morning Session

9.30 A. M.-12.00 M.

Conferences

I

EYE

S. JUDD BEACH, M. D.,
Portland, Me., *Chairman*

External Diseases of the Eye,
M. J. King, M. D., Boston, Mass.

Glaucoma, Paul Chandler, M. D., Boston, Mass.

II

PATHOLOGICAL

MORTIMER WARREN, M. D.,
Portland, Me., *Chairman*

1. Demonstration of Case of Lympho Sarcoma,
Herbert Thompson, M. D., Bangor, Me.
2. Review of Findings of State Pneumococcus Typing Program,
Arch H. Morrell, M. D., Augusta, Me.
3. Coronary Artery Injection Studies,
Julius Gottlieb, M. D., Lewiston, Me.
4. Lesions of the Skin with Lantern Slide Demonstration, Leon Babalian, M. D., and Mortimer Warren, M. D., Portland, Me.

III

SURGICAL

CARL M. ROBINSON, M. D.,
Portland, Me., *Chairman*

Round Table discussion of Post-Operative Complications.

1. Infections,
George A. Tibbetts, M. D., Portland, Me.
2. Urinary Complications and Water Balance,
C. Harold Jameson, M. D., Rockland, Me.
3. Post-Operative Chest Conditions,
William Cox, M. D., Lewiston, Me.
4. Paresis and Intestinal Obstruction,
Harrison L. Robinson, M. D., Bangor, Me.
5. Phlebitis and Parotitis,
Carl H. Stevens, M. D., Belfast, Me.
6. Transfusion and Blood Banks,
Ralph L. Reynolds, M. D., Waterville, Me.

IV

ANESTHESIA

GILBERT CLAPPERTON, M. D.,
Lewiston, Me., *Chairman*

1. Technique in Endotracheal Anesthesia with Detailed Illustration,
Gilbert Clapperton, M. D., Lewiston, Me.
2. The Present Status of Intravenous Anesthesia,
Wedgewood P. Webber, M. D., Lewiston, Me.
3. What the Physician-Anesthetist Offers the Surgeon and Patient Today,
George E. Young, M. D., Skowhegan, Me.
4. Post-Operative Pulmonary Complications and Their Treatment,
S. David Daniels, M. D., Lewiston, Me.
5. Pre-Anesthesia Medication with Special Reference to the Basal Anesthetics,
Edwin M. Fuller, Jr., M. D., Bath, Me.
6. Cyclopropane Anesthesia,
Maurice E. Lord, M. D., Skowhegan, Me.

V

MEDICAL

E. C. COOK, M. D.,
York, Me., *Chairman*

Communicable Diseases

1. The Pneumonia Problem in Maine,
Roscoe L. Mitchell, M. D.,
State Board of Health
2. Scarlet Fever and its Treatments,
Charles B. Popplestone, M. D., Rockland, Me.
3. Infantile Paralysis, Present Status,
Lloyd Bishop, M. D., Portland, Me.

VI

OBSTETRICAL

L. H. SMITH, M. D.,
Winterport, Me., *Chairman*

1. Rural Obstetrics: Some Statistics Pertinent to Deliveries in the Home,
L. H. Smith, M. D., Winterport, Me.
2. Surgical Obstetrics with Special Attention to Symptoms and Treatment of Placenta Praevia,
Walter F. W. Hay, M. D., Portland, Me.
3. The Ideal Hospital Obstetric Service,
Clarence Emery, M. D., Bangor, Me.

VII

PEDIATRICS

CLAIR S. BAUMAN, M. D.,
Waterville, Me., *Chairman*

Some Pediatric Problems of the Respiratory Tract,
Francis McDonald, M. D., Boston, Mass.,
Asst. Prof., Tufts Med. School, Guest Speaker

Luncheon

12.30 P. M.

Tables will be reserved for reunions of alumni of Boston University, Johns Hopkins, Bowdoin, McGill and Harvard University Medical Schools.

Afternoon Session

2.00-5.00 P. M.

Clinico-Pathological Conference

JULIUS GOTTLIEB, M. D.,
Lewiston, Me., *Chairman*

The Clinico-Pathological conference will consist of case presentations as indicated below, with discussion opened by a physician or surgeon to whom the pathological diagnosis is unknown. Following discussions, the Pathologist will present the findings as seen at postmortem.

The first three papers will include complete presentation of the case history and follow up studies at the respective hospitals. The last series, if time permits, will be presented in synopsis form together with the Pathological findings. General discussions will be limited to five minutes.

1. A Case of Unexplained Temperature and Chills,
   Paul R. Chevalier, M. D., Lewiston, Me.
   Discussion: H. C. Knowlton, M. D., Bangor, Me.
   Pathological Findings:
   R. A. Beliveau, M. D., Lewiston, Me.
2. A Case Suggestive of Central Nervous System Disturbances,
   H. E. Thompson, M. D., Bangor, Me.
   Discussion: E. H. Drake, M. D., Portland, Me.
   Pathological Findings:
   H. E. Thompson, M. D., Portland, Me.
3. A Case Presenting Slight Jaundice, Fever and Gastro-Intestinal Disturbance,
   Elton R. Blaisdell, M. D., Portland, Me.
   Discussion:
   William V. Cox, M. D., Lewiston, Me.
   Pathological Findings:
   Mortimer Warren, M. D., Portland, Me.
4. A Brief Synopsis of Case Histories with Unexpected Pathological Findings,
   Julius Gottlieb, M. D., Lewiston, Me.
   A. Headache, Chills, Dyspnea, Cyanosis, Rapid Pulse.
   B. Sudden Death Following a Minor Injury.
   C. Disassociated Symptomatology with Apprehension.
   Discussion: T. E. Hardy, M. D., Waterville, Me.

NOTE: Summation of each case by Reginald Fitz, M. D., Boston, Mass., Professor of Medicine, Boston University Medical School.

5.00 P. M.

Election of President-elect.

5.30 P. M.

Second Meeting of the House of Delegates.

Evening Session

7.00-9.00 P. M.

Dinner-Dancing.

9.00 P. M.

Speech Defects,
James S. Greene, M. D., Invitation Speaker,
New York City

Ladies invited.

TUESDAY, JUNE 27, 1939

Morning Session

9.30 A. M.-12.00 M.

Conferences

I

MEDICAL EXAMINERS

President Oscar F. Larson, M. D., Machias, Me.
Secretary George L. Pratt, M. D., Farmington, Me.
Annual Meeting Maine Medico-Legal Society.

II

NERVOUS AND MENTAL DISORDERS

FORREST C. TYSON, M. D.,
Augusta, Me., *Chairman*

Symposium on Psychoanalysis

Psychoanalysis in Relation to the Psychoses,
Forrest C. Tyson, M. D., Supt.,
Augusta State Hospital, Augusta, Me.

Some Psychoanalytic Conceptions and Therapy of the Psychoneuroses,
Isador H. Coriat, M. D., Boston, Mass.

Papers to be followed by discussion.

III

MEDICAL

HENRY C. KNOWLTON, M. D.,
Bangor, Me., *Chairman*

Program to be announced.

IV

SURGICAL (By Invitation)

GORDON MORRISON, M. D.,
Boston, Mass., *Chairman*

Symposium on Traumatic Surgery

Assisted by
Franklin Balch, Jr., M. D., Boston, Mass.
Sidney Wiggin, M. D., Boston, Mass.

V

EAR, NOSE AND THROAT

L. E. PRATT, M. D.,
Lewiston, Me., *Chairman*

1. Treatment of Common Colds,
   Elmer H. Jackson, M. D., Augusta, Me.
2. Laryngotracheo Bronchitis,
   Harry Butler, M. D., Bangor, Me.
3. Tuberculosis of the Larynx,
   George O. Cummings, M. D., Portland, Me.
4. Mastoiditis, Medical and Surgical Treatment,
   Warren E. Kerschner, M. D., Bath, Me.
5. Carcinoma, Larynx,
   Frederick T. Hill, M. D., Waterville, Me.
6. Lateral Sinus Thrombosis,
   William H. Chaffers, M. D., Lewiston, Me.

VI

GENITO-URINARY

C. HAROLD JAMESON, M. D.,
Rockland, Me., *Chairman*

Urinary Stone

VII

X-RAY

1. The Variation of Radiation, Intensity Depending Upon the Type of Pathology,
   Camp C. Thomas, M. D., Lewiston, Me.
2. Interesting Cases Shown by
   Doctors Thaxter, Goodrich, and others

Luncheon

12.30 P. M.

Past Presidents' and County Secretaries' Luncheons.

Afternoon Session
2.00-5.00 P. M.

SCIENTIFIC

1. Our Disordered Profession,
   Pres. Willard H. Bunker, M. D., Calais, Me.
2. The Chemotherapy of Pneumonia,
   Francis G. Blake, M. D., New Haven, Conn.,
   Professor of Medicine, Yale Medical School
   Discussion Opened by
   Elton R. Blaisdell, M. D., Portland, Me.
3. Treatment of Ordinary Injuries,
   John J. Moorhead, M. D., New York City,
   Professor of Surgery—New York Post-Graduate Medical School
   Discussion Opened by
   William V. Cox, M. D., Lewiston, Me.
4. Rural Community Hospitals,
   John T. Morrison, M. D., New York City
   Discussion Opened by
   Frederick T. Hill, M. D., Waterville, Me.,
   and Frank D. Weymouth, M. D., Brewer, Me.

Evening Session
7.00 P. M.

Annual dinner—(dress informal).

Introduction of visiting delegates.

Presentation of fifty-year medals by
President Willard H. Bunker, M. D.

Burton K. Murdock, Kennebunk, Me.
Representing Maine Pharmaceutical Association.

Banquet Guest Speaker,
Morris Fishbein, M. D., Chicago, Ill., Editor of *The Journal of the American Medical Association*, "American Medicine and the National Health Programme."

NOTE: Medical, Obstetrical, and Surgical Motion Pictures will be shown at various times throughout the session.

GOLF TOURNAMENT

Handicap golf tournament for members of the Maine Medical Association. Eighteen holes to be played either Monday or Tuesday. Kicker's handicap. Three gross and three net prizes.

TO THE LADIES

All of the evening sessions have been made especially attractive for the ladies. There will be dinner dancing on Monday evening. Monday and Tuesday afternoons there will be bridge parties with suitable prizes. Automobiles will be provided for a number of sight-seeing trips. We also have some fine motion pictures for the women who do not play bridge.

MEDICO-LEGAL SOCIETY

Medical Examiners, and others interested, are urged to attend the Conference and Annual Meeting of the Medico-Legal Society on Tuesday, June 27th, 9.30 A. M., at Poland Spring.

Attorney General Burkett will be present, also Attorney Herbert E. Locke, Senator H. C. Marden, and Representative Peter Mills, who all helped very much in getting our bill through the Legislature.

All of the County Attorneys will be invited.

Among other things, we need to consider the situation which will arise in 1941, when the new law goes into effect.

GEORGE L. PRATT, *Secretary.*

GREETINGS TO THE MAINE MEDICAL ASSOCIATION

"The Maine Pharmaceutical Association extends to the Maine Medical Association its best wishes for a happy and successful convention. Grateful to you and your Ambassador, Dr. Adam P. Leighton, in bringing about a closer affiliation of the two professions and earnestly willing to coöperate at all times for a clearer understanding between the two professions and for the benefit of the people which we serve."

CARL C. ANDERSON, *President,*
Maine Pharmaceutical Association.

GREETINGS TO THE MAINE PHARMACEUTICAL ASSOCIATION

The ideals, interests and activities of Pharmacy and Medicine are so closely allied and interwoven, that it is folly indeed to procrastinate further in bringing about that fraternization and more intimate association which two of the oldest professions in history should enjoy. Never was the time more propitious. Each of us needs the other, and we should give immediate and special thought to the various details of interprofessional relations. These two time-honored organizations must join forces and work together with whole-hearted cooperation and coördination in effort to the end that our mutual problems may be more easily circumvented.

Scientifically educated and trained men, as are we, working along almost identical lines of endeavor, must realize how important it is that we maintain our high and century-old standards of practice. We have too much in common to allow for the slightest misunderstanding.

Medicine and pharmacy have undergone a curious transition in the past three decades. The problems are many. Doctors have been thoughtless in their dealings with the druggists. Ethics, perhaps, seems a lost art. The influx of foreign professional men has caused unfair competition. The spectre of Socialized Medicine looms ahead. Cult practice has increased tremendously. Rank commercialism in certain instances within the pharmaceutical profession has done irreparable harm to each of us. The time has come for us to sit down and sensibly contemplate what is best for the future of Medicine and Pharmacy.

For many years I have advocated that we join hands with the druggist and allow for an interchange of delegates at our Annual Meetings. President Bunker has designated me as Delegate to the Maine Pharmaceutical Association at their June meeting, and I am pleased indeed for this privilege. The Pharmaceutical Association will send a delegate to our meeting at Poland Spring. We shall greet him warmly and enjoy his presence.

May this be just the starting point for an increased friendly interest and a better understanding, each for the other.

ADAM P. LEIGHTON, M. D.

Official Delegates to the Eighty-Seventh Annual Session of the Maine Medical Association, 1939

State Societies

New Hampshire:
A. J. Provost, Manchester.
Henry L. Stickney, Togus (Maine).

Vermont:
W. H. McBride, Island Pond.

Massachusetts:
Frank W. Snow, Newburyport.
Charles F. Warren, Amesbury.

Connecticut:
Clyde L. Deming, New Haven.
Alfred C. Henderson, Stamford.

Rhode Island:
Daniel V. Troppoli, Providence.
J. Murray Beardsley, Providence.

County Medical Societies

Androscoggin:
D. F. D. Russell, Leeds.
L. A. Sweatt, Strong.
W. E. Webber, Lewiston.

Alternates:
R. A. Goodwin, Lewiston.
H. L. Gauvreau, Lewiston.
B. Beliveau, Lewiston.

Aroostook:
W. B. Gibson, Houlton.
H. E. Small, Fort Fairfield.

Alternates:
Storer Boone, Presque Isle.
Arthur Whitney, Houlton.

Cumberland:
L. A. Brown, Portland.
W. D. Anderson, Portland.
J. C. Oram, South Portland.
F. A. Smith, Westbrook.
Ralph A. Heifetz, Portland.
D. H. Daniels, Portland.

Franklin:
C. C. Weymouth, Farmington.

Hancock:
M. A. Torrey, Ellsworth.

Alternate:
J. H. Crowe, Ellsworth.

Kennebec:
Samuel H. Kagan, Augusta.
Charles E. Towne, Waterville.
Chalmers G. Farrell, Gardiner.
Howard F. Hill, Waterville.

Alternate:
Ivan E. McLaughlin, Gardiner.

Knox:
Howard Apollonio, Camden.
A. J. Fuller, Pemaquid.

Alternates:
Gilmore Soule, Rockland.
John B. Curtis, Brownville Junction.

Oxford:
E. M. McCarthy, Rumford.

Alternate:
John A. Green, Rumford.

Penobscot:
L. J. Wright, Bangor.
Henry C. Knowlton, Bangor.
Forrest B. Ames, Bangor.
H. C. Scribner, Bangor.

Alternates:
L. H. Smith, Winterport.
C. H. Burgess, Bangor.
H. D. McKay, Old Town.
Asa Adams, Orono.

Piscataquis:
F. J. Pritham, Greenville Junction.

Alternate:
R. H. Marsh, Guilford.

Sagadahoc:
A. F. Williams, Togus.

Somerset:
W. H. Walters, Fairfield.

Alternate:
W. S. Milliken, Madison.

Waldo:
Foster C. Small, Belfast.

Alternate:
Carl H. Stevens, Belfast.

Washington:
John F. Hanson, Machias.

Alternate:
James Bates, Calais.

York:
S. A. Cobb, Sanford.
C. W. Kinghorn, Kittery.

Alternates:
W. H. Kelley, Biddeford.
J. H. MacDonald, Kennebunk.

Maine Pharmaceutical Association

Burton K. Murdock, Kennebunk

Delegate to the American Medical Association

William A. Ellingwood, Rockland.

Delegates to State Societies

New Hampshire:
George L. Pratt, Farmington.

Massachusetts:
Carl M. Robinson, Portland.

Rhode Island:
George R. Campbell, Augusta.

Connecticut:
Eugene E. O'Donnell, Portland.

Vermont (1938):
Foster C. Small, Belfast.

Delegate to Maine Pharmaceutical Association

Adam P. Leighton, Portland

Convention Rates

Poland Spring House
Poland Spring, Maine

The following Room Rates, which include all meals, will prevail:

Single rooms without bath .....$6.00 per day
Double rooms without bath, per person .....$6.00 per day
Double room and single room with connecting bath, for 3 persons, per person .....$7.00 per day
Two double rooms with connecting bath for 4 persons, per person .... $7.00 per day
Double room with bath for 2 persons, per person .....$7.00 per day
Single room with bath, per person ....$8.00 per day

The charge for non-registered guests for meals will be as follows:

Breakfast $1.50
Luncheon $2.00
Dinner $2.50

Golf green fees will be $1.00 per day. The tennis courts and Beach Club will be available without charge.

The Hotel Orchestra will be available four hours each day for dancing.

Poland Spring Water, both Natural and Carbonated, will be served at all times to the guests of the hotel.

For reservations write the Poland Spring House, Poland Spring, Maine.
Make your reservations early!!

Commercial Exhibits at Eighty-Seventh Annual Session

George C. Frye Co., Portland, Maine.

It is the plan of the George C. Frye Co., to present a most complete assembly of the latest in diagnostic equipment, office furniture and physicians' supplies.

Our representatives, Claude Lamson, Sidney Cheney and Edward Jones will be present to greet their friends.

M & R Dietetic Laboratories, Inc., Columbus, Ohio.

"Similac, a completely reconstructed powdered milk for infants deprived of breast feeding, will be on display. Messrs. John J. Krancer and Arthur M. McCormick will gladly explain the value of the zero curd tension of Similac as it applies to both normal and special feeding cases."

The Thomas W. Reed Company, Boston, Massachusetts.

The Thomas W. Reed Company of Boston, Mass., are pleased to announce that at the coming Maine Medical Convention, Mr. J. F. Walsh will be in charge of the display.

The latest type of Short Wave Apparatus, Pedestal Operating Tables and Portable Operating Lights will be exhibited, in addition to many other items, particularly interesting to Physicians.

Surgeons' and Physicians' Supply Co., 761 Boylston Street, Boston, Massachusetts.

"The Surgeons' and Physicians' Supply Company exhibit will be in charge of our local representative, Mr. C. H. Joy.

We will exhibit as far as possible a line of new and interesting items as well as equipment that can not usually be shown by a salesman. We will have a Comprex short wave, X-Ray, lamps, etc., including the new Hyfrecator, which we recommend your seeing."

General Electric X-Ray Corporation, 624 Beacon Street, Boston, Massachusetts.

General Electric X-Ray Corporation will show an Electrocardiograph, Model F-3 Portable X-Ray Machine, Model C Electrosurgical Machine, Diagnostic View Box.

Portable X-Ray machine, suitable for all types of portable radiography, as well as light office work.

New modernized Electrocardiograph, simple, portable and durable.

New type Diagnostic View Box, which improves diagnostic values of all X-Ray films.

Newly designed Spark Gap Electrosurgical Unit for all types of electric surgery, including desiccation and electrocoagulation.

Elmer N. Blackwell, 207 Strand Building, Portland, Maine, Surgical Appliance Exhibit.

Outstanding as an exhibit each year, since 1926, is the display of Corrective and Surgical Appliances which Mr. Blackwell brings to the Medical Meeting. You will find every reliable body appliance and many special designs available for men, women and children, that fill a definite need in such cases as Ptosis, Sacro-Lumbar Strain, Hernia, Leg Conditions, Arch and Foot Weakness, and Abdominal abnormalities. Mr. Blackwell invites you to take the opportunity at this meeting to inspect his line and become acquainted with these physiological supports. Mr. Blackwell will be pleased to explain or help with any problem involving support and show what the profession is using on their cases.

The Denver Chemical Mfg. Co., 163 Varick Street, New York City.

"Antiphlogistine, now in its forty-sixth year, is employed by physicians in all parts of the world in the treatment of inflammatory and congestive conditions. Members are invited to visit the exhibit and take a package of Antiphlogistine. Galatest, a new micro-reagent for the instantaneous detection of urine sugar, will be demonstrated. This product has made a profound impression wherever it has been introduced."

The P. J. Noyes Company, Pharmaceutical Chemists, Lancaster, New Hampshire.

We are grateful for the opportunity of contributing in a modest way towards the success of the meeting of the Maine Medical Society.

Joe E. Brown, Representative.

E. R. Squibb & Sons, 745 Fifth Avenue, New York City.

Physicians attending the Maine Medical Association convention are cordially invited to visit the Squibb Exhibit in Booth No. 9.

The complete line of Squibb Vitamin, Glandular, Arsenical and Biological Products and Specialties, as well as a number of interesting new items will be featured.

Well informed Squibb Representatives will be on hand to welcome you and to furnish any information desired on the products displayed.

Mead Johnson & Company, Evansville, Indiana.

Mead Johnson & Company will exhibit their complete line of infant diet materials and representatives will be on hand to discuss with physicians the application of the products.

John Wyeth & Brother, Inc., Philadelphia, Pennsylvania.

John Wyeth & Brother, Incorporated, of Philadelphia will exhibit at Booth No. 10. Wyeth is best known for its pharmaceutical specialties such as: Silver Picrate, in powder and suppository form for the treatment of trichomonas vaginalis; Amphojel, Wyeth's palatable alumina gel, for the safer control of hyperacidities and the treatment of peptic ulcer; Kaomagma, the absorbent for diarrhea and intestinal disturbances; and Mucara, processed karaya gum indicated in intestinal stasis.

Lederle Laboratories, Inc., The Statler Building, Boston, Massachusetts.

Lederle Laboratories, Inc., will have a display consisting of a full line of biologics featuring the 32 types of antipneumococcic therapeutic serum now available and a line of pharmaceutical specialties featuring our Vi Delta Emulsion.

Tailby-Nason Company, Boston, Massachusetts.

"Tailby-Nason Company of Boston will exhibit Nason's Palatable Cod Liver Oil, made in the company's own plants in the Lofoten Islands of Norway, romantic Land of the Midnight Sun.

Nason's oil is prescribed and recommended by leading pediatricians from the Atlantic to the Pacific for its high vitamin potency and unusual palatability.

In addition, this old established Pharmaceutical house will display several of the most recent developments of its research and pharmacological laboratories."

J. B. Lippincott Company, Philadelphia, Pennsylvania.

The Coca-Cola Company, Atlanta, Georgia.

"The Coca-Cola Company will ice and serve Coca-Cola complimentary to the delegates attending the Annual Session."

The C. B. Fleet Company, Inc., Lynchburg, Virginia.

Phospho-Soda (Fleet) is a highly concentrated and purified, aqueous solution of sodium phosphates. It is non-toxic, rapid and mild in action without irritation of the gastric or intestinal mucosa. Indicated for hepatic dysfunction, and for its thorough eliminating and cleansing action on the upper and lower intestinal tract.

The C. B. Fleet Co. thank the medical profession for the broader usage being given to Phospho-Soda (Fleet). Its prompt, acceptable and controllable action makes it an exceptionally efficient laxative saline and cholagogue.

Sharp & Dohme, Philadelphia, Pennsylvania, Striking New Sharp & Dohme Display.

Sharp & Dohme will have their new modern display at space 4 this year, featuring their well-known Propadrine Hydrochloride Products and new "Lyovac" Bee Venom Solution for the treatment of arthritis. There will also be on display a group of pharmaceutical specialties and bio-

Always DEPENDABLE PRODUCTS

Pharmaceuticals . . . Tablets, Lozenges, Ampoules, Capsules, Ointments, etc. Guaranteed reliable potency. Our products are laboratory controlled.

Zemmer

PRESCRIBE or DISPENSE ZEMMER

Write for catalog.

Chemists to the Medical Profession.

***The* ZEMMER COMPANY**

Oakland Station, PITTSBURGH, PA.

MA-6-39

logicals prepared by this house. Capable, well-informed representatives will be on hand to welcome physicians and furnish information on Sharp & Dohme products.

Picker X-Ray Corporation, 920 Beacon Street, Boston, Massachusetts.

To the Roentgen Profession the name of Picker-Waite has always been synonymous with progress. The first successful Shockproof X-Ray Apparatus ever built was of Waite invention.

Production facilities plus the combined resources of the Picker-Waite Organization, with an electrical and mechanical engineering background of over fifty-nine years, have made it possible to produce X-Ray equipment at a modest cost.

One of the most outstanding pieces of Picker-Waite equipment is the Picker-Waite Century (100 Milliampers—100 Kilovolts) which has been presented to the medical profession as a truly modern diagnostic X-Ray apparatus . . . introducing for the first time an entirely new principle of flexibility in radiographic-fluoroscopic X-Ray design and development.

Point for point and dollar for dollar, the Picker-Waite Century is easily the most outstanding value in diagnostic X-Ray equipment offered to a discriminating clientele.

We are proud to exhibit this unit with many new and outstanding smaller accessory devices at the meeting of the Maine Medical Association.

Bulletins and descriptive literature may be obtained at our booth.

Petrolagar Laboratories, Inc., 8134 McCormick Boulevard, Chicago, Illinois.

Physicians are cordially invited to visit the booth of Petrolagar Laboratories, Inc., where Messrs, Schneider and Tarplin will be in attendance.

Petrolagar is liquid petrolatum 65 cc. emulsified with 0.4 Gm. agar in a menstruum to make 100 cc., accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the specialized treatment of constipation.

Scientific drawings and literature on the subject of constipation will be available in addition to samples of the five types of Petrolagar.

Codman & Shurtleff, 66 Plympton Street, Boston, Massachusetts.

Est. 1838.

This corporation has catered to the needs of the profession for over 100 years. We specialize in rebuilding and sharpening instruments, carry a complete line of general medical and surgical supplies and equipment. Under our new policy, a representative will call on the profession at regular intervals. We shall be glad to coöperate with any surgeon in the manufacturing and designing of any instrument to suit his special form of technique. Our reputation your guarantee.

Arlington Chemical Company.

H. P. Hood & Sons, Charlestown, Massachusetts.

H. G. Fischer & Company, Chicago, Illinois.

MEMBERSHIP CARDS

Members *must* present membership cards before registering at the annual session.

Treasurer's Report

Chester A. Jordan
Harold C. Jordan

Members of American
Institute of Accountants

JORDAN & JORDAN
ACCOUNTANTS AND AUDITORS
Fidelity Building
Portland, Maine

May 31, 1939.

MAINE MEDICAL ASSOCIATION AND JOURNAL,
PORTLAND, MAINE.

Gentlemen:

We respectfully report that we have completed our audit of your accounting records for the fiscal year ended May 31, 1939, and have found the same complete and correct in all details of record. Statements annexed hereto are, in our opinion, properly drawn up to show the true financial position of the Association May 31, 1939, and the income and expense for the year under review.

Respectfully submitted,

JORDAN & JORDAN,
Accountants and Auditors.

MAINE MEDICAL ASSOCIATION AND JOURNAL

Balance Sheet, May 31, 1939

ASSETS

Cash in Banks		$14,775.97
Accounts Receivable—Sundry		252.50
Dues Receivable—1939		112.00
Advertising Receivable—1939		353.59
Securities (Cost) (See Schedule Attached)		7,405.00
Furnishings and Equipment		948.93
Impounded Cash		1,754.14
Deferred Expenses—Annual Meeting Expense		43.25
Total Assets		$25,645.38

TRUST FUND INVESTMENTS

Prince A. Morrow Fund:—			
12 Shares American Agricultural Chemical Co. (Cost)	$348.00		
Savings Account No. 3905, Canal National Bank	430.84		
Savings Account No. 54236, Fidelity Trust Co., Impounded	72.82		
		$ 851.66	
Thayer Library Fund:—			
Savings Account No. 3903, Canal National Bank	$845.41		
Savings Account, No. 54631, Fidelity Trust Co., Impounded	404.44		
		1,249.85	
Total Fund Investments			2,101.51
Total Assets and Fund Investments			$27,746.89

LIABILITIES AND CAPITAL

Deferred Income:—		
Exhibit Space—1939 Exhibition	$ 779.50	
Capital Account—May 31, 1939	24,865.88	
Total Liabilities and Capital		$25,645.38

TRUST FUNDS

Trust No. 1—Prince A. Morrow Fund	$ 568.52		
Unexpended Income	283.14		
		$ 851.66	
Trust No. 2—Thayer Library Fund	$1,229.72		
Unexpended Income	20.13		
		1,249.85	
Total Trust Funds			2,101.51
Total Liabilities, Capital and Trust Funds			$27,746.89

Capital Account, One Year Ended May 31, 1939

Balance—June 1, 1938		$25,563.58
Deduct:—Expenses, Herbert E. Locke, Attorney, relative to legislative matters, paid with Capital Funds	$1,034.92	
Loss—Fidelity Trust Co., Checking Account—Maine Medical Journal—Final Dividend received	24.45	1,059.37
		$24,504.21
Add:—1934-35-36 Dues Received	$ 24.00	
Net Gain—One Year	337.67	
		361.67
Balance—May 31, 1939		$24,865.88

Statement of Revenue and Expense, One Year Ended May 31, 1939

REVENUE

Dues	$5,744.00
Income from Securities	326.50
Interest Received	228.40
Exhibit Space—1938 Convention	664.50
C. M. A. B. Advertising	2,156.11
Local Advertising	1,193.55
Subscription and Sales of Journals	17.20
Total Revenue	$10,330.26

EXPENSE

Salaries:—		
Dr. Jackson, Editor	$1,000.00	
Augusta Office—Dr. Carter, Secretary and Treasurer	1,000.00	
Assistant	113.00	
Portland Office—Mrs. Kennard, Assistant Secretary	1,500.00	
Assistants	12.50	
Traveling Expenses:—		
President's	200.00	
Secretary's	150.00	
Councilors'	107.94	
Office Expenses:—		
Supplies, Stationery, etc.	298.74	
Postage and Mailing Expense	262.50	
Telephone	129.57	
Auditing	56.50	
Miscellaneous	108.73	
Committees	68.85	
Clinical Session	108.89	
A. M. A. Meeting	253.50	
Medical Advisory Committee	500.00	
Annual Meeting	866.57	
Printing	3,216.75	
Plates	38.55	
Total Expense		9,992.59
Revenue in Excess of Expense—One Year		$337.67

STATEMENT OF CASH RECEIPTS AND DISBURSEMENTS, ONE YEAR ENDED MAY 31, 1939

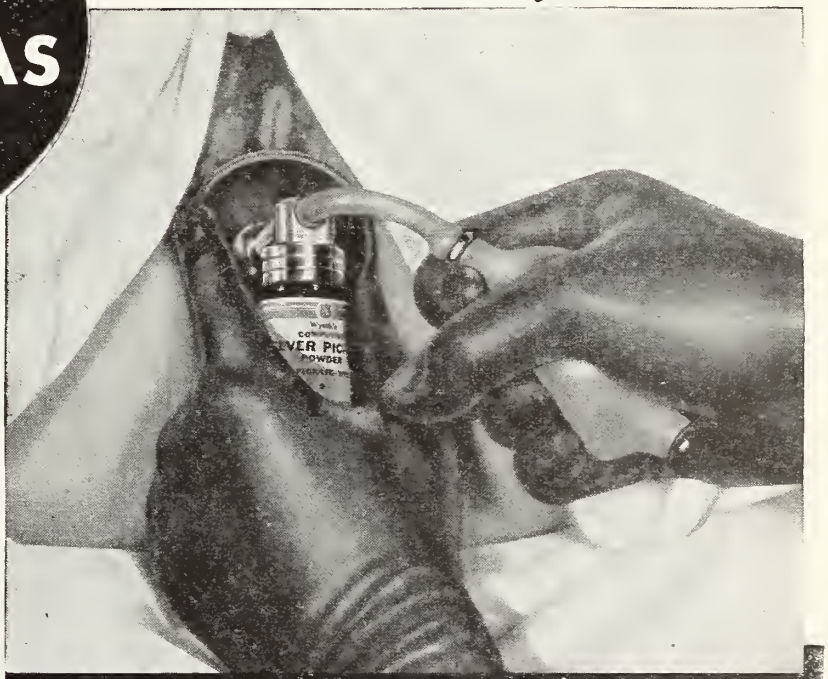
Cash in Banks June 1, 1938		$15,523.97

RECEIPTS

Received from Dues	$5,712.00	
Income from Investments	554.90	
Exhibit Space Rentals	820.50	
Liquidating Dividends—Fidelity Trust Co.	212.04	
Subscription and Sale of JOURNAL	17.20	
Advertising	3,280.62	
		10,597.26
		$26,121.23

A CONVENIENT OFFICE TREATMENT FOR TRICHOMONAS VAGINITIS

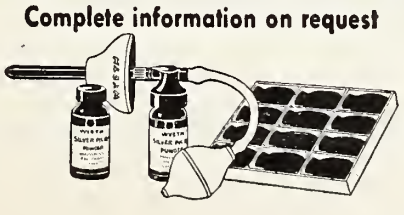
SILVER PICRATE
Wyeth



THIS simple treatment requires but two office visits, a week apart, for insufflations and the nightly insertion of a Silver Picrate suppository for twelve nights.

Complete remission of symptoms and removal of the trichomonad from the vaginal smear usually is effected following the Silver Picrate treatment for trichomonas vaginitis.

Complete information on request



JOHN WYETH & BROTHER, INCORPORATED, Philadelphia, Pa.

DISBURSEMENTS

Salaries	$3,625.50	
Traveling Expenses	457.94	
Office Expenses	856.04	
Committees, Clinical Session and A. M. A. Meeting	431.24	
Annual Meeting—1938 and 1939	909.82	
Medical Advisory Committee	500.00	
Printing and Plates	3,255.30	
New Equipment	274.50	
Herbert E. Locke, Atty.—re Legislative Matters	1,034.92	
		11,345.26
Cash in Banks—May 31, 1939		$14,775.97
Canal National Bank—Checking Account	$4,408.47	
Canal National Bank—Savings Account	1,706.87	
Maine Savings Bank	4,348.20	
Portland Savings Bank	4,312.43	
		$14,775.97

SECURITIES—BONDS, MAY 31, 1939

		Cost	*Market*
$2,000	Commonwealth of Australia, Ext. Loan 30 Yr. 5's, 1957	$1,960.00	$1,990.00
700	Prudence Bond Corp. 1st Mtge. Coll. Series 6, 5½'s, 1936 (Defaulted)	700.00	273.00
3,000	Portland Terminal Co. 1st Mtge. 5's, 1961	3,045.00	2,977.50
1,700	Mortbon Corp. of N. Y. Reg. Coll.	1,700.00	
$400	June 1, 1941, A 5's		392.00
400	1946, B 5's		296.00
400	1951, C 5's		216.00
500	1956, D 5's		315.00
10 Shares	V. T. Class A, $1—Par		28.75
		$7,405.00	$6,488.25

A Reliable Source of vitamin D
of Consistent Potency

OLD TAVERN FARM
IRRADIATED Vitamin D
Milk

The Journal
of the
Maine Medical Association

Volume Thirty | Portland, Maine, July, 1939 | No. 7

*Our Disordered Profession**

By W. H. Bunker, M. D., Calais, Maine

How unfortunate that in this land of plenty, with abundant resources—a land in which the allied sciences have approached the peak of perfection—that the peace and tranquility which rightly belongs to us should be so overshadowed by so much unrest, greed, instability and disregard for human happiness.

Unfortunately these undesirable qualities are not confined to any one group of people but are scattered here and there among all organizations and we do not appear to be exempt.

Certainly we are living in an era that will go down in history as the age of Scientific Achievements.

In our own profession, on all sides, we see evidence of skill which denotes the highest type of intelligence.

Even in this modest assembly hall, a meeting place for the members of our State Association, we are surrounded by men who, because of their high degree of intelligence and technical training must be regarded as authorities in their own line of work.

To many of these men go the undisputed honor of having been responsible for some particular achievement in their line of practice, the details of which they are only too willing to convey to their brother members.

This is only one example of the gracious spirit and generosity of many of the leaders of our profession. Most assuredly such men as Claudeus Galen, Koch, or Pasteur, if allowed to spend a few short hours on this hemisphere during our present generation, would be shocked and amazed at the wonderful scientific achievements accomplished by the Medical Profession and they would indeed regard it as the Age of Miracles.

Many pages could be written without repetition on the scientific advancement of medicine, but justice would not be done my subject without showing some consideration to the social side of our practice which, due to the exigencies of a busy life, appears to be somewhat neglected.

After serving three years on the Council of the Maine Medical Association, one year as President-Elect, and this year as your President, I am more than ever satisfied that our legal and social activities require far

* President's Address. Read at the 87th Annual Session of the Maine Medical Association, Poland Spring, Maine, June 27, 1939.

more consideration than has been customary in the past and unless more wholehearted coöperation is manifested on the part of many of our members I hesitate to predict the final outcome of our organization, for certainly inactivity, lack of coöperation, professional greed and jealousy, will be important factors in deciding the destiny of our profession.

Money alone will not buy legislation, neither will it purchase success or happiness.

They can only be obtained by years of diligent labor and by working with our fellow members in friendly accord.

You are all aware of the fact that we are living in a period that demands action. We cannot with self-complacency fold our hands and place our hopes in the future.

As a Medical Organization we have been represented to the people by the government as a body of men incompetent of rendering adequate medical service to the needy and indigent.

Even our honesty and integrity have been questioned. We have been accused of misdemeanor and obliged to face a tribunal which will render its verdict in due time.

Our professional activities have been directed by politicians laboring under the guise of humanitarians who certainly have little knowledge of the first principles of medical need or medical ethics.

In fact a very carefully prepared program has been offered us for adoption which, if accepted by us as outlined, or forced upon us by legislation, will certainly spell disaster to our clientele and practically demoralize our own profession.

This fact must be granted by the members of our Association and yet, confronted by such a calamity, what are we as members of the Maine Medical Association, doing to prevent it?

In discussing the subject of "Government Controlled Medicine" I do not wish to infer that I am in any way prepared to offer a solution for this situation but refer to it only as an example to strengthen my point relative to the importance of keen legislation and social activities during these unsettled times.

Are we doing all in our power to solve the legislative affairs of our organization, or are we prone to place the entire responsibility upon the shoulders of a few who are willing to sacrifice an unlimited amount of time and money for the good of our society?

Are we willing to throw our whole-hearted support into the work of rebuilding and remodeling a program which will be in accord with the fair-minded people of our country, a result of which the indigent and needy may be adequately cared for by our medical profession, thus allowing us to remove forever any thought of regimented medicine which is so distasteful to us all?

Are we willing to take an active part in our State and County Societies or would we prefer to remain at home because of inclement weather or a similar excuse?

Do we subscribe to and read diligently our State Journal or would we choose to casually glance at the headlines and offer unfavorable comments?

Do we support the officers of our State Association and stand behind them in their various decisions?

Are we willing to curb those unkind remarks made at the opportune moment and strive to conduct ourselves in an ethical manner, thus avoiding those unpleasant and nerve-wracking experiences of the so-called malpractice cases so often inflicted on brother members of our profession and their families as well, while the offender gets little or no satisfaction, but, instead, many hours of remorse and deep regret.

And last, but by no means least, do we live up to the "Code of Ethics" adopted by the American Medical Association and the recommendations of the Judicial Council of that Association rendered at their annual meeting in San Francisco in 1938, thereby setting an example for the younger members of our profession by which they may be directed in the proper channels, so that in years to come they may be better and wiser men because of their relations with us?

The excellent scientific qualifications previously referred to cannot build a State Medical Society, neither can they carry us through a period such as we are now facing.

Questions are continually arising that would try even the patience of Job himself.

If there ever was a time in the history of

our Society when all members should work in unison, it is now.

New laws must be made and obeyed in order that we may even exist as an organized society, for this very day while many of us are serenely happy with our success as professional men, blessed with the security of a good home and a comfortable income, different agencies representing our Government in Washington are carefully and stealthily weaving a web about us in the form of the Wagner Act, so securely that unless we rise up as an organized body and fight for a true cause and the opportunity to practice honest and ethical medicine, free from the unsound recommendations of our dictators, we will most certainly be engulfed in a stream of chaos and be compelled to step down from the high position which we now hold and become servants of the public, laboring under the jurisdiction of the lawmakers of our country.

We must not forget that we are living in a scientific, pleasure-loving age, surrounded by selfishness, greed and aggressive ambition.

We love this land of ours, but we should be ever mindful that the Clock of Eternity keeps excellent time.

Social Aspects of Tuberculosis—The prevention of tuberculosis is not merely a public health problem but also a powerful social and economic factor which affects the economic structure of the entire nation.

"At a time when all values have tumbled and numerous assets have to be classified as frozen, the health and productivity of the people remain the outstanding and most tangible resources of a nation and it would be the short-sighted policy of the penny-wise and dollar-foolish to curtail preventive health measures for the sake of economy," says Dr. Karl Fischel of Saranac Lake.

The tuberculosis problem is closely linked with other momentous issues of the day, and the tuberculosis death rate of the future is, therefore, bound to be affected by the solution of other problems, be it unemployment, inflation, commodity prices or disarmament. (From an essay awarded the Leon Bernard Memorial Prize for 1938 by the International Union Against Tuberculosis) Fischel, Karl, Bull. de l'Union contre Tuberc., 1939, 16.

Metastases to the skin occur more often than has been supposed. In an autopsy series of 2,298 malignant tumors of various types, 2.7 percent had metastases to the skin. Their importance lies in the fact that they are not uncommonly the first evidence of the existence of malignancy and also of metastasis. Contrary to current belief, metastases to the skin do not always herald approaching death but may precede the terminal event by months or even years. They are of limited value in prognosis since the behavior of the skin tumors does not necessarily indicate rate of growth of the primary tumor.—Olive Gates, *The Am. Jour. of Cancer,* August, 1937.

"A major impediment to maternal health, and, consequently, to child health, is syphilis. Yet it is one of the most easily correctable factors involved. A blood test of every pregnant woman— as soon as she knows she is pregnant—will reveal syphilis if it is present. Treatment begun early will mean that she can bear a healthy child. Five months' treatment during pregnancy is better than five years' treatment after the birth of the child.

"No mother objects to a silver nitrate solution in her baby's eyes. She knows it protects it against blindness from gonorrhea. She would not object to a blood test for determining the presence of syphilis or to the treatment for syphilis if she understood its importance to her baby. And her own infection might have been prevented if the State in which she lived had required a blood test before marriage."

"The major indirect cost of syphilitic blindness, is loss of earning power. Assuming that each blind person unable to support himself represents a loss of earning power of $1,000 a year, Dr. Rice estimates an annual loss of $43,000,000 for all blind. Loss of earnings from blindness caused by syphilis amounts to approximately 15 percent of the total."

Congenital Hypertrophic Pyloric Stenosis

By Eaton Shaw Lothrop, M. D., F. A. C. S.

Hypertrophic pyloric stenosis in infants is considered by most authorities to be of congenital origin, as it has been found in infants of the later prenatal months. One case is reported in a seven-months' fetus.

It is about seven times as common in male children as in females. It occurs in about one male child in every two hundred, usually occurring in breast-fed children. Some claim that it is due to recurrent spasm of the circular muscle fibres of the pyloric ring and canal. It would seem rather incredible that there could develop such marked hyperplasia as a result of spasm, especially when we find this disease in very young infants and even before birth.

The view of Gray & Pirie that the spasm is due to hyperadrenalism, associated with the irritation of a long prepuce—thus explaining its frequency in boys, is not supported by further investigation, for it has been found in Jewish children and there is never any evidence of hyperadrenalism.

The clinical picture is uniform but striking. The diagnosis rests on the spitting up of food, beginning shortly after birth and becoming progressively worse until after 3 or 4 weeks the vomiting becomes projectile, the stools becoming less frequent and smaller, and in the fully developed case, the gastric peristalsis with its ball-like waves is easily recognized. In advanced cases, the pyloric tumor can be felt when the stomach is empty. The five major signs are: (1) Failure to gain in the absence of fever or other infection, (2) persistent vomiting of the projectile type shortly after feeding, (3) visible gastric peristalsis moving from left to right, (4) scanty stools, (5) palpable tumor.

The evidence in recent years has made it manifest that in an established case there is little or no hope of cure by medical treatment. In the early stages when the diagnosis is in some doubt, careful attention to the diet and long treatment should certainly be tried, but when once the diagnosis is certain, an operation should be performed before the condition is advanced. The results of operative treatment, if performed early, are so satisfactory and the after-progress so remarkably good, that there can be no hesitation in advocating this form of treatment.

Surgical treatment was first attempted in 1898. Its evolution to the present time has been quite remarkable. The original surgical procedure was about the same as used on an adult for pyloric stenosis. Some operations, suggested and tried in the treatment of this disease, have been pylorectomy, plastic operation of the Mikulicz type, that is cutting the muscles longitudinally and attempting to suture them transversally, and forcible dilatation after gastrotomy, also posterior gastroenterostomy. The mortality is high in such extensive operation when performed on an infant already greatly weakened by its inability to retain food.

In 1912, Rammstedt demonstrated a simpler operation. Not only is the type of operation important for success but also the preoperative and post-operative care. One or two days may be required to put the child in the proper condition for operation. Every attempt should be made to overcome the extreme dehydration with accompanying acidosis. Rectal and subcutaneous salines with or without glucose should be administered at regular intervals also directly before operation. A hot water bottle may be placed under the child during operation.

The Rammstedt operation consists in incising longitudinally through the serosa and thickened muscles, dividing them down to the mucosa. A two-inch right upper para rectus incision is made relatively high so that in a small child this lies over the liver. A finger can be hooked below the liver and the thickened pylorus felt at once and easily withdrawn. The tumor is held between the thumb and index finger of the left hand. Beginning at the duodenal end, an incision is made over the entire extent of the tumor in its least vascular part and through the peritoneum and superficial part of the circular muscle only. The cut muscular edges are separated well up on to the stomach by a blunt instru-

ment until the mucuous membrane bulges into and completely fills the incision. There is a certain amount of danger of perforation of the mucosa at the duodenal end for here the pylorus ends abruptly. In the event of perforation close the opening by purse string and suture omentum over it. Evisceration at operation adds to shock and care should be taken not to allow this. Drop the pylorus back into the abdomen. The liver falls back over the line of incision so that the abdominal wall can be easily and rapidly closed.

The after treatment is very important for the child is likely to collapse owing to its dehydrated condition. Subcutaneous saline should be administered periodically. Body heat must be maintained. The case should be turned over to a pediatrician immediately after operation.

The most important consideration is that the feedings should be small in quantity. The gastro-enteritis which so frequently complicates convalescence, and which is very often the cause of death, is largely due to unwise administration of large quantities of food before the alimentary canal has regained its normal tone. There is a novel explanation for the diarrhea which frequently complicates convalescence. Before operation it is said that diarrhea is due to the growth of the colon bacillus in the alkaline intestinal tract; most of the acid gastric juice is lost by vomiting, but the pancreatic juice continues to flow and to alkalinize the duodenum and upper jejunum. After operation, however, when food is retained and passes through the intestinal tract, fermentation of the carbohydrates takes place and diarrhea naturally follows.

All writers emphasize the importance of getting the child out of the hospital as promptly as possible, the brevity of the stay after surgery being one of the chief arguments in this type of therapy. The English writers are particularly emphatic on this point. Wallace and Wevill report six patients in their series who were discharged a few hours after operation. Rutherford mentions a five-weeks-old child who was taken home 3 hours after operation and kept out-of-doors after the second day. If early discharge is not feasible, he advocates the rather utopian scheme of relays of nurses delegated to hold the child in their arms and thus insure constant body warmth.

The immediate results of operation will depend very largely upon the time at which it is undertaken. Among the poorer hospital classes, where treatment is often delayed, the results are less satisfactory, and although there is a steady improvement in this direction, most general hospitals still show a mortality rate of 20 to 25%. Individual series have given much better results than this. In the Children's Hospital and Infants' Hospital of Boston, in a series of 425 cases from 1915 to 1931, the total mortality rate was 6.3%.

In a series of 44 cases at the Maine General and Children's Hospitals from 1933 to the present time there is a mortality rate of 6.8%.

The after history of these cases is of very considerable interest. Schlesinger has reported the end results of a series, and has laid stress upon the fact that children so treated attain to an almost abnormal fitness. They have never once looked back and their weight and height were considerably above the normal.

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The life expectancy for untreated cancer of the esophagus, in the median case, is 7 months, for cancer of the stomach, 13, and for cancer of the rectum 14 months after the onset of the first symptom directly referable to the disease.

The median life expectancy of all patients with treated cancer of the stomach in this series is 15 months.—Ira T. Nathanson and Claude E. Welch, *The Am. Jour. of Cancer,* November, 1937.

*Sulfanilamide and Sulfapyridine in the Treatment of Pneumonia**

A REPORT OF 36 CASES

By Benjamin Zolov, M. D., Chief of Medical Service, Farrington Hospital, and
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Review of Literature

During the past two years, a major portion of the medical literature has been devoted to the use of sulfanilamide in various diseases. For the past six months, the use of a related drug, sulfapyridine, has again stimulated interest in the field of chemotherapy in this country. The purpose of this paper is to describe the use of both of these drugs in the treatment of pneumonia. A brief review of the literature, will precede our own experience with these drugs.

Sulfanilamide has proved bacteriostatic against types I, II, III, and XIV pneumococci in vitro and in laboratory animals, according to various authors. While the drug probably has been used widely for human pneumococcic pneumonia, the reports to date are meager. Heintzelman, Hadley and Mellon used it in nine cases of types III, and obtained seven recoveries, whereas among ten controls there were only two recoveries. Millet reported one case of type III pneumonia in which a crisis occurred after the use of sulfanilamide. Louis added six cases of pneumococcic pneumonia in which recovery occurred with sulfanilamide therapy.

Price and Myers describe 115 cases of pneumococcic pneumonia treated with sulfanilamide. An initial dose of 15 grains to 20 pounds of body weight was given to all patients; those over 160 pounds received a maximum dose of 120 grains. This total dosage was then continued, being divided into six equal doses, given every four hours. An equal amount of sodium bicarbonate accompanied each dose of sulfanilamide.

The toxic manifestations in their series include cyanosis in almost every case, anorexia, and nausea, lassitude, headache, and drowsiness, morbilliform rash in two cases, seven cases of fever, and acute hemolytic anemia in six cases. They compared the 115 cases treated with sulfanilamide with 40 cases treated with Felton serum and 94 controls who received no specific therapy.

The results were analyzed from the standpoint of the type of pneumococcus, average age of the patients, duration of the pneumonia before treatment, extent of the consolidation, blood culture, initial white cell count, duration after the onset of treatment, associated diseases and complications. The mortality rate was 15.7 per cent for the entire sulfanilamide group and 30.8 per cent for the controls. The death rate for 57 patients with types I, II, V, VII, and VIII pneumonia treated with sulfanilamide was 10.5 per cent, whereas it was 27.5 per cent for 40 patients with the same types treated with serum. Of 21 patients with pneumococcic bacteremia treated with sulfanilamide, seven died; of 12 treated with serum, six died; and of 15 controls, 13 died. The most important toxic manifestation was anemia. In 5.2 per cent of the patients treated with sulfanilamide a severe hemolytic anemia developed and in an additional 18.2 per cent moderate secondary anemia developed.

Sulfapyridine or Dagenan, its trade name, was first prepared by Dr. A. J. Ewins and Mr. M. A. Phillips in the chemical research laboratories of May & Baker, Ltd., at Dagenham, England. Its development was the culmination of a large number of experiments undertaken in an effort to find a drug that was effective against the pneumococcus and at the same time possessed a chemotherapeutic index sufficiently favorable to justify its clinical use. Whitby demonstrated that Dagenan had a specific action against the pneumococcus, and Evans and Gaisford determined its value in the treatment of lobar pneumonia in human beings.

* Read before the Portland Medical Club, May 2, 1939.

Sulfapyridine is a white crystalline powder with a melting point of 190.5° F. Sulfapyridine, as compared with sulfanilamide, is relatively insoluble in water.

In a series of 200 cases of pneumonia, Evans and Gaisford administered sulfapyridine to approximately alternate patients admitted to the hospital, the control group receiving routine nonspecific treatment. The mortality rate in the 100 controlled cases was 27 per cent, whereas in the 100 patients who received sulfapyridine, there were only eight deaths. It was noted that the temperature fell within 48 hours in 60 of the patients treated with sulfapyridine, while in the control group this occurred in 34 of the patients. On the basis of case mortality rates, clinical courses, and temperature curves in the two groups, it was concluded that sulfapyridine exerted a definitely beneficial effect on the course of the disease.

Dyke and Reid reported results obtained with sulfapyridine in the treatment of eight cases of lobar pneumonia. In this small series it was found that chemotherapy was followed by a rapid fall of the temperature and pulse-rate and by improvement in the clinical condition. In all cases in which the drug was administered in full and efficient dosage, it is stated that the subsequent course was uneventful and rapid recovery ensued.

Barnett, Hartmann, Perley, and Ruhoff treated 23 infants and children with this drug. This series included 14 cases of pneumonia, three of which were complicated by empyema, and one of these was further complicated by purulent pericarditis; four cases of bronchitis; three cases of pneumococcic peritonitis; one case of influenzal meningitis, and one case of subacute bacterial endocarditis (Streptococcus viridans).

The results obtained with sulfapyridine in the cases of pneumonia were confirmatory of those previously cited. A dramatic fall in temperature occurred in every case of pneumonia within 28 hours of the institution of chemotherapy, and the decline in temperature was followed by rapid improvement in the clinical condition of the patients.

Wilson reports 70 cases of pneumonia in children, half of whom were treated with sulfapyridine. The administration of sulfapyridine apparently shortened the course of pneumonia by three to four days. By statistical analysis it was demonstrated that the fall in temperature and the clinical recovery were significantly earlier in the sulfapyridine group than in the control group. Wilson also found that a dosage which secures a level of free sulfapyridine in the blood of approximately four milligrams per hundred cubic centimeters is therapeutically adequate.

Barnett reports two cases of pneumonia complicated by empyema which showed no improvement by the drug. Despite the fall in temperature and the general improvement of the patients, fluid continued to collect in the pleural cavity and cultures from it remained positive. Resections of ribs with open drainage of the empyema were done in both cases, and the patients made uneventful recoveries.

When sulfapyridine is administered orally, it is absorbed fairly rapidly from the gastrointestinal tract, although not in such constant amounts as is sulfanilamide. Within a short time after administration, sulfapyridine may be detected in the blood by means of a test in which it is transformed into a colored dye substance. This is then compared with known standards prepared from pure sulfapyridine.

Long and Feinstone report that the drug is found in purulent pleural exudates and in the spinal fluid in concentrations of from one-half to two-thirds of these observed in blood. Infection, or some factor accompanying infection, may alter the amount appearing in certain body fluids or exudates.

With average effective therapeutic doses, the blood levels of free sulfapyridine usually range from three to six milligrams per 100 cubic centimeters. In adults the blood level occasionally may rise to ten milligrams or more per 100 cubic centimeters for appreciable periods. Barnett et al. report that these higher blood levels are more commonly observed in infants and children. It is not known as yet why the percentage acetylated varies so widely in different individuals. In general, blood levels of free sulfapyridine are lower than those obtained with similar doses of sulfanilamide.

Both the free and acetylated forms of sulfapyridine are apparently excreted almost entirely through the kidney, but excretion does not proceed so rapidly as with sulfanila-

mide and may be retarded in the presence of renal impairment. Stokinger has reported complete excretation of free sulfapyridine within 24 hours following the administration of a single dose, whereas Long and Feinstone have found that excretion may continue for three or four days after a single dose. Barnett et al. report that following cessation of chemotherapy the drug remained in exudates in appreciable quantities for several days, while at this time only traces were found in the blood.

Method of Study

The Farrington Hospital is maintained by the City of Portland, Maine, for treatment of indigent cases. Approximately 175 patients can be accommodated; a large percentage of whom come from homes receiving city aid. During the four months, from January 1, to May 1, we treated 36 cases of pneumonia here. Of these, 12 were treated with sulfanilamide and 24 with sulfapyridine.

Since we had decided to review our pneumonia cases, the following laboratory procedures were carried out in each case, as the minimum requirements:

(1) Throat Culture, sputum typing and blood culture.

(2) Red Blood Cell count, White Blood Cell count, and Hemoglobin Determination.

(3) X-Ray of Chest.

(4) Blood Determination for Sulfanilamide or Sulfapyridine levels.

As our bacteriological facilities at the Farrington Hospital were inadequate, our culture work and pneumococcus typing were done by the laboratories of the Maine General and State Street Hospitals. We experienced a great deal of difficulty in obtaining pneumococcus typings from the throat cultures of children in our series of cases, a condition reported by many other workers. Our diagnoses were based upon definite physical findings confirmed by X-Ray in every case.

Routine blood level determinations were carried out in our own laboratory, along with the usual hematological studies. Facilities for blood determinations were started too late to be used on children who received sulfanilamide in this series. We feel that it is most important in employing this type therapy, that blood level determinations be carried out, since the procedure can be adequately carried out with ordinary laboratory equipment.

Method of Treatment

Our general routine of treatment was as follows:

Children on entry were seen by one of us, and after a careful history was elicited from parents, the child was thoroughly examined. Throat cultures and routine blood work were carried out before therapy was started. This is very important when using sulfapyridine, as the sputum may become negative for typing shortly after starting the drug. Chest X-Rays were taken as soon after entry as possible. As a large percentage of the children were markedly dehydrated and malnourished, clyses of 5% glucose in distilled water, or 5% glucose in normal saline, were given soon after entry. Those children who were found to show low red blood cell counts or who were extremely malnourished were given small transfusions of citrated blood.

Evidence of respiratory distress or cyanosis on entry was treated by placing the patient in an oxygen tent. Restlessness was combated by the use of repeated small doses of codein or elixir of phenobarbital. Syrup of hydriotic acid was given for cough.

Until sulfapyridine became available, seven of the children were treated with sulfanilamide. In general, for this group of children, whose ages ranged from ten months to four years, 5 grains (.32 grams) of sulfanilamide were given every four hours, day and night, until an adequate clinical response was obtained. We determined our dosage by definite clinical improvement in the condition of the patient and later by blood level findings rather than by the age or weight. With this evidence of improvement, the administration of the drug was gradually reduced. Our total dosage, ranged from 2 grams to 10 grams, averaging 6 grams for the seven cases. An equal amount of sodium bicarbonate was given in each case.

The procedures used in children were also carried out in the five adults, with addition

of more available sputum typings. Also morphine was given for restlessness, and elixir of terpene hydrate with codein was given for cough. The usual initial dose of sulfanilamide was 2 grams, followed by 1 gram every four hours. Total dosage here ranged from 15 grams to 40 grams averaging 26 grams. Average sulfanilamide determinations in this group were found to be 7 milligrams per 100 cubic centimeters of blood.

The total number of cases treated with sulfapyridine was 24. Of these, 13 were children and 11 adults. Our general management of these cases was the same as for those previously mentioned, except that sulfapyridine was given instead of sulfanilamide.

In this group the youngest child treated was two months of age, and the oldest was eight years. Best results were obtained with the following dosage:

(1) Up to six months of age one-fourth gram of sulfapyridine was given initially, followed by one-eighth gram every four hours.

(2) From six months to one year, one-half gram of sulfapyridine was given as initial dose, followed by one-fourth gram every four hours.

(3) Older children received 1 gram for the initial dose and one-half gram every four hours.

These doses were maintained until there was definite evidence of resolution of the pneumonic process by physical examination. *Initial fall in temperature was not considered sufficient reason for diminishing the dose.* Another important factor in continuing the dosage was the determination of the sulfapyridine level in the blood. Our best results were obtained with an average of 7.9 milligrams per 100 cubic centimeters of blood, maintained until physical signs showed definite improvement. The smallest total dosage given was 5⅛ grams, while the largest was 21 grams, the entire group averaging 16 grams. At this point it should be noted that certain individuals, although given large doses of the drug by mouth, failed to show the expected blood sulfapyridine level. We encountered this condition in a three-month-old infant and in a 38-year-old male. Four of the children treated in the series presented signs and symptoms of pneumonia following whooping cough, of an average of one month's duration. This latter group received 150 to 300 milligrams of Cevitamic acid daily, during the acute phase of the disease, continuing until the "whooping episodes" had subsided.

Among the ten adults treated, ages ranged from 38 years to 83 years. Here we used an initial dose of 2 grams of sulfapyridine, followed by 1 gram every four hours, day and night. The same criteria were adhered to in subsequent reduction of the drug, as has been mentioned above in its use with children. An average blood sulfapyridine level of 9.3 milligrams per 100 cubic centimeters was maintained in the adults. The total dosage ranged from 10 to 50 grams, with 33 grams as average for the group.

Case History Abstracts

Case 31. S. C. This 59-year-old, white, married, female, entered the hospital because of pains in the chest with chills and cough of five days' duration. Since the onset of her chills she had been confined to bed. She had been treated at the dispensary for "bronchitis", for the past five years.

Examination on entry revealed an extremely emaciated appearing elderly female, in obvious respiratory distress. On percussion of chest, there was definitely impaired resonance at the right base. Tactile fremitus was increased in this area, with breath sounds bronchial, and increased whispered and spoken voice sounds. Her abdomen was distended and tender.

Within 24 hours after entry, temperature rose to 104° (F) rectally, and patient became moribund, and markedly cyanotic. At this time she was placed in an oxygen tent, and administration of sulfapyridine started. Her white blood cell count was 19,800, red blood cell count 3,800,000, and hemoglobin 63 per cent. The sputum was reported, pneumococcus type VIII. X-Ray of her chest revealed consolidation of the right lower lobe. Blood cultures were negative, while blood Hinton was reported positive. She was given 1 gram of sulfapyridine as initial dose, with continued dosage of 1 gram every four hours. Twenty-four hours after administration of

the drug, her temperature fell to normal, and at this time the blood sulfapyridine level was 8.6 milligrams per 100 cubic centimeters. White blood cell count at this time fell to 15,500. The drug was continued in the same doses day and night for five days until the patient had received 30 grams. For the last three days, a total of 4 grams was given in diminishing doses. In all she received 34 grams.

The blood sulfapyridine determination on the 3rd, 4th, 5th, and 6th days, were 7, 10, 8, and 9.5 mg. per 100 cc., respectively. The white blood cell count dropped from 9,900 on the 3rd day to 5,000 on the 5th day, returning to 9,000 on the 6th day. During the first week of illness abdominal distension became marked, and she was treated for this complication. There was moderate nausea and occasional vomiting throughout the treatment. On the 5th day after the start of sulfapyridine administration, the patient was well enough to be removed from the oxygen tent. Convalescence was uneventful and she was discharged from the hospital 14 days after entry.

Case 8. F. B. This 19-year-old, white, housemaid, entered the hospital complaining of cough, chest pain, and hemoptysis of two days' duration. Past history revealed that the patient had been troubled by intermittent asthmatic attacks since childhood. Three weeks before entry the patient had been discharged from the Isolation Hospital where she had been treated for a month as a diphtheria carrier. Following discharge from the Isolation Hospital she was well until five days before entry when she started to be troubled by cough. The day before entry, her temperature was 104° (F). Twenty-four hours later she was admitted to the hospital.

Physical examination revealed a malnourished, young, white female, in marked respiratory distress. Physical signs indicated consolidation at both bases, which was confirmed by X-Ray findings. Her abdomen was moderately distended; she appeared very irrational and drowsy.

Sputum revealed no pneumococcus types 1 to 32, on direct typing, while sputum culture showed S. P. aureus, and Hemolytic streptococcus. Her temperature was 105° (F) rectally, white blood count 17,000, red blood count 3,800,000, hemoglobin 70%.

The patient was in an oxygen tent for the first six days of her illness. On the second day she was started on sulfanilamide, 1 gram every four hours. Delirium was marked for the first three days. On the third day her white blood count was 21,850, red blood cell count 4,300,000, hemoglobin 70. Blood sulfanilamide at this time was 5.2 mg. per 100 cc. On the sixth day white blood cell count was 27,050, red blood cell count and hemoglobin showed no change. On the eighth day blood sulfanilamide was 5.7 mg. W. B. C. was 14,650, R. B. C. 3,320,000.

Temperature dropped to normal on the 10th hospital day. Convalescence thereafter was uneventful and she was discharged 21 days after entry.

Case 13. J. F. A two-month-old, white, male infant, weighing 8½ pounds was sent to the hospital because of cough for three weeks, with listlessness, refusal of feedings, and respiratory distress on day of entry. He had been exposed to whooping cough at home, and when admitted his cough was paroxysmal in type.

Examination showed an extremely emaciated, cyanotic male infant, coughing, and breathing with labored respirations. His temperature was 100.4° (F), respiratory rate 116. There were scattered patches of consolidation throughout both sides of the chest revealed by physical signs, and confirmed by X-Ray. Abdominal distension was noted.

The infant was immediately placed in an oxygen tent, and sulfapyridine started. One-quarter of a gram was given initially, repeated in four hours, and then one-eighth gram every four hours after that. The day after entry, the infant's temperature fell to 99.8° rectally, and his condition appeared worse. One hundred cubic centimeters of citrated whole blood was given by vein and coramine ¼ c.c. was given every four hours. On the third day condition was still very poor, his temperature was 103.2° rectally, respirations were 116. The child became extremely cyanotic when taken from the tent for a few minutes. Coramine and sulfapyridine were continued, and as fluids were being taken poorly, clyses of 60 to 100 C.C. of

5% dextrose in distilled water alternating with normal saline were given every eight hours.

Three-sixteenths of a grain of ephedrine sulfate was given every four hours. This regime was continued to the 5th day, when the patient's condition showed improvement. The temperature had reached normal at the end of the 4th day. It should be noted that this patient received 150 mgs. of cevitamic acid daily for six days because of the exposure to whooping cough. One-forty-eighth of a grain of codein was given every four hours for restlessness.

Throat cultures from this patient revealed pneumococci, but typing could not be established. The blood culture showed no growth. Blood sulfapyridine after four days of therapy was 15.3 mgs. per 100 c.c., W. B. C. 16,000, R. B. C. 3,610,000, hemoglobin 66%. As chest signs persisted, the sulfapyridine was continued and after six days was 9.5 mgs. per 100 c.c., while W. B. C. was 26,500, and hemoglobin was 65%. He was well enough to be taken out of the oxygen tent at the end of the eighth day and codein was discontinued. Blood sulfapyridine was only 4.5 mgs., W. B. C. 19,500, hemoglobin 63%. Chest signs were clearing, and at this time the night doses of sulfapyridine were discontinued, completely omitting the drug a day later. Convalescence from here on was uneventful, although some cough persisted for another week. This infant received a total of eight and one-half grams of sulfapyridine, and was discharged well at the end of 30 days.

Case 28. J. M. This 40-year-old, white, male, clerical worker entered the hospital with a history of having been treated for pneumonia six weeks previously. At that time he remained in bed for only one week, returning to work against his physician's advice and despite a persistent cough, and weakness. His strength was apparently failing, until three days before entry, at which time he was too weak to get out of bed. He complained of pains in the right chest, severe cough, and fever. His condition became worse during the next two days, and on the day of entry a physician was called and he was sent to this hospital.

Examination revealed an emaciated, pale, white, male with a severe cough, raising thick white sputum, irrational and appearing markedly toxic. Chest examination disclosed dullness to flatness from the right mid chest to the base, with distant to absent voice and breath sounds at the right base posteriorly. The left lung was clear and resonant. X-Ray showed consolidation of the right middle and lower lobes with definite fluid at the right base.

Sputum typing was reported as type IV pneumococcus. Temperature 100.4° rectally on entry, rising to 102° within 12 hours. The W. B. C. was 16,000, R. B. C. 4,000,000, and the hemoglobin 65%.

He was immediately started on sulfapyridine, receiving 5 grams within the first 12 hours. For the next six days he received six grams of sulfapyridine daily and on the seventh day he received 5 grams. The temperature fell to normal after two days of treatment and remained normal for the next four days. On the second day after entry a diagnostic thoracentesis was done, withdrawing 150 c.c. of foul swelling purulent fluid which contained chains of streptococci on smear. The following day a closed thoracotomy was done, using a metal drainage tube. The report on the fluid cultured at this time revealed anaerobic streptococci. On the fifth day the patient complained of abdominal pain and showed marked distension. Within 48 hours he had developed a paralytic ileus. This was treated with Wagenstein suction for small bowel decompression, rectal tubes, hot packs, enemas, surgical pitnitrin and physostigmine.

During treatment with sulfapyridine, the patient's blood sulfapyridine level ranged from 10 to 13 mgs. On the eighth day the W. B. C. was 24,000, hemoglobin 65%, the temperature rose to 101° rectally, and the sulfapyridine was discontinued. A transfusion of 300 c.c. of citrated whole blood was given, and sulfanilamide therapy was started the next day because of the streptococcic empyema. Due to his condition the sulfanilamide was given by vein, in saline, until the continuous suction was removed. During the next week the patient was given three more transfusions of citrated whole blood, and from the 8th to the 23rd day he received

74 grams of sulfanilamide. This was given in doses of 8 grams daily and gradually was reduced. On the 21st day his temperature reached normal. However, on the 23rd day despite the normal temperature his pulse rate was 120, and since it had been increasing daily for the past three days, it was decided to discontinue the sulfanilamide. This resulted in a gradual return to normal of the pulse rate. Blood sulfanilamide averaged 9½ mgs. per 100 c.c.

The patient's distension was relieved after seven days of treatment. The empyema of the chest had been treated by continuous tidal drainage of the chest space with normal saline, through the thoracotomy tube. The empyema cavity gradually closed off and the tidal drainage was discontinued after 18 days.

Convalescence from here on was uneventful, and the patient was discharged on the 45th hospital day. Checkup X-Rays revealed obliteration of the empyema cavity and the thoracotomy wound healed well.

Case 1. S. R. This ten-month old female infant, entered the hospital with a history of cough and "running ears" of two weeks' duration. Three days before entry, the cough grew worse, the child was very listless, refused feedings, and started to vomit on the day of entry.

Physical examination revealed a well developed and well nourished child, who appeared very drowsy. Examination of the ears revealed an inflamed left drum; the right drum was normal. Chest signs indicated consolidation at the left base, with medium moist rales throughout both bases. X-Ray confirmed these findings.

Temperature was 104° (F) rectally, and W. B. C. was 29,350. Sulfanilamide was started 24 hours after entry, and 2½ grains were given every four hours. Small clyses of normal saline were given every eight hours, when necessary, and the child was placed in an oxygen tent immediately.

Two days after entry, an otolaryngologist saw the child and paracentesis of both ears was performed. The patient maintained a septic temperature, ranging from 101° (F) to 106° (F) rectally.

Two small transfusions were given five days after entry when R. B. C. was 2,970,000, W. B. C. 41,800, and hemoglobin 57%. The ears stopped draining within 48 hours after the drums were incised.

One week after entry she developed marked distension of the abdomen with edema of the lower extremities. Despite all supportive measures, her condition grew worse, generalized edema set in, and on the tenth day she expired.

Case 34. C. C. This 79-year-old, white, female, was admitted from the chronic ward of the Boothby Home. She had been an inmate there for the past five years and had been under treatment for cardiac decompensation and asthma on several past occasions. For two days previous to entry she had been vomiting and listless, and on the day of entry had become semi-comatose with labored respirations.

Examination revealed an elderly, white, female, in moderate respiratory distress. Her pulse was irregular and weak, temperature was 104° (F)rectally. Chest examination revealed consolidation throughout the entire right side. Heart sounds were of fair quality with irregular rhythm, rate 120.

She was started on digitalis. Three grains were given every four hours. Twenty-four hours after entry sulfapyridine was given, two grams as the initial dose, followed by one gram every four hours. She also received 1 c.c. of coramine every four hours.

No sputum could be obtained for typing, but a blood culture, taken during a chill, was negative. Blood counts on admission were, W. B. C. 30,700, R. B. C. 4,820,000, hemoglobin 75%. Twenty-four hours after sulfapyridine administration the blood level was 11 mgs. per 100 c.c. She received a total of nine grams of sulfapyridine before death.

Two days after entry, her condition suddenly grew worse and she expired.

Complications and Toxic Manifestations

As with sulfanilamide, the toxic effects of sulfapyridine are sufficient to require careful usage of the drug and close observation of the patient.

Nausea with vomiting is the most constant and frequent side effect with sulfapyridine.

No serious constitutional effects have been reported as a result of this untoward reaction, aside from the obvious loss of fluids and salts. In the sulfanilamide treated cases the above symptoms were less marked. With both drugs severe toxic effects of utmost importance include acute hemolytic anemia and neutropenia which may be severe enough to classify as agranulocytosis. Unless daily blood counts and hemoglobin estimation are made, these serious reactions may not be detected. Up to the present, withdrawal of the drug and institution of appropriate therapy, particularly blood transfusion, have resulted in recovery. Toxic hepatitis, hematuria, anuria, urinary calculi, drug rashes and drug fever have been observed. In our series, two of the children developed a macular rash following administration of sulfapyridine. Sulfapyridine should be discontinued immediately upon the discovery of any severe reactions. Anemia and neutropenia are especially significant when noted during the early stages of severe pneumococcic infections. A large percentage of our cases exhibited marked leukopenias which we feel were due to the drug, since withdrawal resulted in a return to normal.

Cyanosis attributed to the use of sulfapyridine has been noted in a number of cases. However, it is rarely so marked as with sulfanilamide, and has not necessitated withdrawal of the drug. In pneumonia, cyanosis is quite frequent as a result of the disease, and any increase due to the drug is difficult to assess. There is no established proof that cyanosis is due to the formation of sulfhemoglobin, but, as in the case of sulfanilamide, it is suggested that saline laxatives and sulfur-containing foods be avoided during the administration of sulfapyridine.

Central nervous system disturbances include vertigo, headache, malaise, mental depression, and occasionally excitement severe enough to be classed as toxic psychosis has been observed in a few cases.

Not infrequently it has been observed that discontinuing the drug too soon after the clinical response has been obtained may result in a recurrence of the infection. We noted recurrences in three instances. Cases 19 and 20 among the children, and case 35 among the adults. Subsequent daily maximum dosages in these cases resulted in final recovery.

Statistics

Among the 36 cases in this series, we encountered 16 cases of lobar pneumonia in the adult group, whereas among the children treated here, we found only five cases of lobar pneumonia, with 15 cases of broncho pneumonia. In the sulfapyridine group, the following type pneumococci were found: I, III, IV, VI, VIII, and XIX. Hemolytic streptococcus and non-hemolytic streptococcus and B. influenza were reported in several cases. In both groups we encountered cases which could not be typed under pneumococcus groupings, 1 to 32.

Among the sulfanilamide treated cases we found that the average number of treatment days before temperature returned to normal was 5½ days for the children and 11½ for the adults. Whereas among the sulfapyridine treated cases, the average number of treatment days before temperature returned to normal was two days for children and 36 hours for adults. In averaging the number of hospital days before discharge, the figures concerning children were not used, because several of them came from such poor home environment that they remained here a month or two after they were well.

Those adults treated with sulfanilamide averaged 20¼ days in the hospital whereas the sulfapyridine group averaged 13 days. The entire series of 36 cases was free of any major complications with one exception. However, in the sulfanilamide group we noted three cases of acute otitis media which required parcentesis. No empyemas developed in any of our cases, although one case entered the hospital six weeks after onset of pneumonia, with definite signs and symptoms of empyema. This case, J. M., is discussed above.

In the sulfanilamide group, we had one mortality. This occurred in a ten-month-old female infant. One death also occurred in the sulfapyridine group, in a 79-year-old female, who entered the hospital moribund. These cases were also outlined above. The mortality for the sulfanilamide group in this series was 8.3%. The sulfapyridine group had a mortality of 4.2%.

Summary

(1) Thirty-six cases of pneumonia treated at the Farrington Hospital, are reviewed in this paper. Of these, twelve were treated with sulfanilamide, and twenty-four with sulfapyridine.

(2) In this small group it was observed that the sulfanilamide treated cases required a longer period of hospitalization, and did not respond as well as the sulfapyridine treated cases. However, we feel that in this small series the drug cannot be fully evaluated.

(3) Sulfapyridine treated cases showed a dramatic fall in temperature, with clinical improvement, following adequate therapy with this drug. The excellent results obtained here warrant further use of the drug in the treatment of pneumonia. No serum was used in these cases.

(4) Outstanding toxic manifestations in both groups were cyanosis, nausea and vomiting, with two cases of drug rash observed in children in the sulfapyridine treated group.

(5) One death is reported in each group. The mortality for the sulfanilamide group was 8.3%, and for the sulfapyridine group it was 4.2%.

Sulfanilamide Cases

Case No.	Age	Sex	Total Amount Given	Type Pneumonia	Complications
1. S. R.	10 mos.	F.	6 grams	Broncho Pneumonia	Ottis media, bilateral; paralytic ileus. Expired 9 days after entry
2. B. G.	10 mos.	F.	6 grams	Right lower lobe	Otitis media, bilateral
3. D. P.	1 yr.	F.	8 grams	Broncho Pneumonia	None
4. A. P.	1 yr.	M.	2 grams	Broncho Pneumonia	None
5. R. B.	18 mos.	M.	5 grams	Broncho Pneumonia	None
6. T. C.	2 yrs.	M.	10 grams	Left lower lobe	Otitis media, bilateral
7. P. M.	4 yrs.	F.	5 grams	Broncho Pneumonia	None
8. F. B.	19 yrs.	F.	23 grams	Left lower lobe Right lower lobe	None
9.*R. B.	23 yrs.	F.	30 grams	Right lower lobe	None
10. F. E.	30 yrs.	M.	15 grams	Lobar entire right lung	None
11. H. H.	45 yrs.	F.	24 grams	Left lower lobe	None
12.†A. B.	65 yrs.	M.	40 grams	Right mid-lobar	None

Sulfapyridine Cases—Children

Case No.	Age	Sex	Total Amount Given	Type Pneumonia	Blood Sulfapyridine Average Level	Complications
13. J. F.	2 mos.	M.	8½ grams	Broncho Pneumonia	9.2 mgms.	
14. E. N.	3 mos.	F.	5⅜ grams	Broncho Pneumonia	2.8 mgms.	
15. P. C.	3½ mos.	M.	5¾ grams	Broncho Pneumonia	8.5 mgms.	
16. M. M.	8 mos.	F.	17½ grams	Broncho Pneumonia	4.2 mgms.	Macular rash
17. S. D.	10 mos.	F.	15½ grams	Broncho Pneumonia	11.1 mgms.	
18. D. P.	14 mos.	F.	14 grams	Broncho Pneumonia	9. mgms.	
19. J. F.	2½ yrs.	M.	17 grams	Lobar L. L. L.	9.2 mgms.	
20. M. M.	2¾ yrs.	F.	21 grams	Broncho Pneumonia	12.1 mgms.	
21. J. P.	3 yrs.	F.	12 grams	Broncho Pneumonia	7.5 mgms.	
22. M. L.	3 yrs.	M.	7½ grams	Lobar R. U. L.	9.1 mgms.	
23. D. G.	4 yrs.	M.	12½ grams	Broncho Pneumonia	4.5 mgms.	
24. D. D.	7 yrs.	F.	19 grams	Lobar R. M. L.	8. mgms.	
25. R. V.	15 mos.	M.	18 grams	Broncho Pneumonia	8.5 mgms.	Macular rash

SULFAPYRIDINE CASES—ADULTS

Case No.	Age	Sex	Total Amount Given	Type Pneumonia	Blood Sulfapyridine Level	Complications
26. F. C.	38 yrs.	M.	50 grams	Lobar R. L. L.	3.5 mgms.	
27. H. W.	39 yrs.	F.	18 grams	Lobar R. U. L.	12.4 mgms.	
28. J. M.	40 yrs.	M.	46 grams	Empyema Rt. Base	10.5 mgms.	Paralytic ileus.
29. M. M.	38 yrs.	F.	33 grams	Lobar R. L. L.	3.2 mgms.	
30. M. S.	57 yrs.	M.	10 grams	Lobar R. U. L.	13.3 mgms.	
31. S. C.	59 yrs.	F.	34 grams	Lobar R. L. L.	7. mgms.	
32. M. C.	71 yrs.	F.	48 grams	Lobar R. L. L.	15. mgms.	
33. W. F.	72 yrs.	M.	16 grams	Lobar L. U. L.	6.3 mgms.	
34. C. C.	79 yrs.	F.	9 grams	Rt. Lung	11. mgms.	Expired 2 days after entry.
35. M. L.	83 yrs.	F.	33½ grams	Lobar R. L. L.	8.1 mgms.	
36. O. M.	41 yrs.	M.	34½ grams	Lobar R. L. L.	12.4 mgms.	

* Received 80,000 units of type 18 antipneumococcic rabbit serum.

† Received 90,000 units of type III antipneumococcic rabbit serum.

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Sulfapyridine (Dagenan) was supplied by Merck and Co., Inc., in the study of our first ten cases.

We wish to thank Dr. T. Bramhall, Superintendent and Surgeon-in-Chief of the Farrington Hospital, for his fine coöperation in this study, and Miss Marjorie Jensen, R. N., laboratory technician, for her able assistance in the hematological work.

Case History

Mr. C. C. Case No. 48918. Age 33. Patient admitted December 18, 1936, complaining of pain in stomach and diarrhea of one week's duration.

P. I. Patient perfectly well until one week ago at which time he was taken with a chill and diarrhea, chill not noted again. Diarrhea persisted every one-half hour according to mother. Blood noted in stools at least 5 or 6 times. Has had anorexia, no vomiting. L. M. D. was called four days ago for first time. Saw patient again yesterday and sent him to hospital.

Past History: No T. B., no malignancy or diabetes. Usual exanthemata and enanthemata. No scarlet fever, smallpox or diphtheria. No operations, serious accidents or injuries. Patient is a moron. Has done no work except in connection with his father who is a stone mason. B. P. 140/90. Temp. 101, pulse 126, res. 30.

Physical Examination: On admission very well developed and well nourished white male in questionable acute distress.

Head: No masses, no tenderness.

Ears: No discharge, no tophi.

Eyes: Scleri clear, pupils round and react to light and accommodation.

Nose: No discharge.

Mouth: Clean.

Teeth: Fair repair with sordes.

Tongue: Moderately red and coated.

Throat: Slightly injected.

Neck: Not stiff. Trachea in mid-line, no tug. Thyroid not enlarged.

Chest: Symmetrical, equal and good expansion. Resonant throughout, no rales or friction rubs.

Heart: Not enlarged to percussion. Good rate, rhythm and force. No murmurs heard.

Abdomen: Flat. Dullness in both flanks to percussion. Spastic throughout. Tenderness throughout, more marked in right lower quadrant with rebound tenderness.

Reflexes equal and active. No ankle klonus. No Babinski.

White count on admission, 9,200. Neut. 84%. Eosin 0%. Baso. 0%. Lymph 12%. Mono. 2%. H. B. 72%. R. B. C. 4,790,000.

Urine Chemistry: Negative.

Microscopic Examination: Few coarsely granular casts. R. B. C. 14 to 16 per H. P. F. W. B. C. 40 to 20 per H. P. F.

X-ray Abdomen: Plate of upper abdomen with patient in sitting position shows no evidence of gas under the diaphragm. The whole left side of the abdomen shows an area of increased density without any gas in the intestines except just below the right lobe of liver.
Impression—no evidence of intestinal obstruction from this film.

X-ray Chest: Mottled areas of increased density involving both lung fields, but particularly the right with particular dullness just above the right diaphragm. Impression—Broncho-pneumonia, bilateral, but mainly at the right base.

Patient to O. R. Free fluid, straw colored, found in peritoneal cavity. Terminal ileum gangrenous for about 14 inches. Mesentery adjacent to bowel edematous, congested. Resection of gangrenous portion of ileum was done. A lateral anastamosis was made between cecum and ileum. Patient never fully recovered from operation and died next day.

Pathological Report: Specimen measures 25 cm. in length, x 2.5 cm. diameter. The serosa is markedly injected throughout, but particularly in lower third, and shows patchy areas of hemorrhage. On section the mucosa is also swollen, and injected, and appears necrotic; it is covered with a greenish exudate. The adjacent mesentery is also swollen and injected. At the upper end there is a section of about 4.5 cm. of normal appearing intestine. In some places the swelling of the mucosa markedly reduces the lumen, but never completely.

Microscopic: The mucosa throughout the affected area has been almost completely

destroyed and replaced by a thick fibrinopurulent exudate; in the bowel wall generally there is an acute inflammatory reaction, showing congestion, edema, and interstitial hemorrhages, with few polymorphonuclear cells, except in focal collections, where they approach abscess formation. A similar inflammatory reaction is seen in the adjoining mesentery.

Diagnosis: Regional ileitis (acute form).

Post Mortem Examination: Clinical Diagnosis: Terminal ileitis. One week ago patient had a chill, with diarrhea every half hour. Had bloody stools; no nausea or vomiting. Day before death became distended, with flatness over left half of abdomen. Central Nervous System—moronic individual. Respiratory system negative. G. U.—bladder frequency; no lymphadenopathy; no edema. Exploratory operation performed 12/19 for fluid in abdomen. On operation last 12 inches of ileum were found to be dark and gangrenous, mesentery swollen. Resection of ileum done, with side to side anastamosis of ileum to ascending colon. Patient never reacted and died at 8.45 A. M. on 12/20.

Description: Body is that of a well developed and nourished male about 30 years of age, 174 cm. in length. Rigor mortis slight; livor mortis marked. Pupils equal, slightly injected. In skin of lower abdomen, on right, parallel to umbilicus, is surgical scar 15.5 cm. in length. There is some ulceration along gum margins of mouth, particularly on lower jaw. In lt. antecubital fossa are marks of several venapunctures. Abdominal incision well approximated, sutures still in place. In lower end of wound is rubber cigarette drain, which leads down into right pelvis. There is small amount of bloody fluid in abdomen. Second rib is anterior, large, and prominent on both sides.

Thyroid: Not examined.

Thymus: Not found.

Lymph nodes: No general glandular enlargement.

Pleural Cavities: Free, no fluid or adhesions.

Right Lung: 725 gms. Well distended, surface mottled; lower and middle lobes show nodular areas of deep congestion, are not, however, completely consolidated. Also marked edema. Upper lobe fairly dry, bronchi contain frothy hemorrhagic fluid.

Left Lung: 450 gms. Similar in general appearance to right. Lower lobe shows some scattered areas of deep congestion and edema. Upper lobe somewhat similar but less marked edema.

Pericardial Cavity: Pericardium smooth, small amount of fluid.

Heart: 325 gms. T. V. 12 cm. P. V. 7 cm. R. W. 5 mm. R. C. 10 cm. M. V. 12 cm. A. V. 7 cm. L. W. 22 mm. L. C. 10 cm. Aorta smooth, valves normal, coronary openings normal. Heart muscle good character. Considerable epicardial fat on right side.

Abdominal Cavity: See intestines.

Spleen: 325 gms. 14 x 10 x 3.5 cm. Has deep sulcus. On section is dusky red color, follicles evident, fairly juicy.

Rt. Kidney: 210 gms. 11 x 7 x 3 cm. Similar in appearance to left.

Lt. Kidney: 230 gms. 12 x 7 x 3cm. On section substance is quite pale. Cortex somewhat irregular, average diameter 7 mm. Markings very distinct. Capsule strips readily, leaving smooth surface with injected blood vessels.

Adrenals: Normal.

Pancreas: Normal.

Liver: 2,300 gms. 28 x 20 x 10 cm. On section rather greasy, consistency somewhat decreased, markings rather indistinct. Brownish-gray color.

Gall Bladder: Not distended, not obstructed, no stones.

Intestines: Stomach and duodenal membrane normal, except that duodenum is somewhat injected. In R. L. Q. is lateral anastamosis between remaining ileum and cecum, which is still well approximated. Stump of ileum has been turned in. Mucous membrane of cecum and adjoining colon appears to be normal, but that of sigmoid, rectum, and transverse colon appears to be edematous, somewhat thickened, and slightly hemorrhagic. Mucous

membrane of remainder of small intestine normal. As one approaches distal portion it is rather thin, brownish color.

Bladder: Not distended.

Genitalia: Normal male.

Cranial Cavity: Not opened.

Anatomical Diagnosis:

1. Congestion and edema of lungs, possible broncho-pneumonia.
2. Acute splenic tumor.
3. Parenchymatous degeneration liver.
4. Cloudy swelling of kidneys.
5. Free fluid in abdominal cavity; no perforation or signs of septic peritonitis.
6. Intestinal tract remaining after resection shows no definite lesions, except for congestion and edema of sigmoid area.

Cause of Death: Evidence of sepsis, and from history, post-operative shock. Tissue No. 1127/36—Portion of ileum—Diagnosis: "Regional ileitis (acute form)."

Microscopic:

Lungs: Patchy broncho-pneumonia, apparently originating around bronchioles and spreading into lung in interstitial tissues; both lungs similar.

Spleen: Endothelial hyperplasia, with many phagocytes and erythrocytes.

Liver: Cloudy swelling of many of liver cells, with edema and congestion around central vein.

Kidneys: Moderate cloudy swellings of tubules, and some chronic interstitial nephritis.

Colon: Mucosa partially ulcerated, necrotic, and infiltrated with poymorphs and small hemorrhages.

Heart: Some edema of muscle fibers.

Summary:

Bilateral broncho-pneumonia.

Cloudy swelling of liver and kidneys.

Endothelial hyperplasia of spleen.

Congestion and ulceration of sigmoid colon.

Post-operative shock (following resection of intestine because of terminal ileitis).

COMMENT

George A. Tibbetts, M. D.

In commenting upon a case of regional ileitis, I believe that mention should be made in terminology, for this condition is often spoken of as Terminal Ileitis and since the pathological process may occur at other portions of the ileum it seems better to classify the condition as Regional Ileitis, while at the same time recognizing that the most frequent location of the disease is at the terminal ileum.

Evidently Regional Ileitis is a rare condition to be diagnosed but there is no doubt but that it is more common than we have believed, for since it has been definitely recognized as a disease, more and more cases have been reported. In the past, no doubt, some of these cases have been thought to be due to Tuberculosis and at times extensive Carcinoma.

When once recognized the findings at operation are very striking the lead pipe feel of the disease area plus the characteristic color formation at the junction of the intestine and the mesentary.

Although the above case was not diagnosed prior to operation as soon as the abdomen was opened and the bowel was delivered into the wound, the diagnosis was instantly obvious because of the characteristic findings.

The greatest difficulty in these cases is apparently in arriving at a diagnosis before operation for a definite diagnosis would assist greatly in choosing the proper surgical procedure.

This case illustrates, for here we were dealing with an extremely sick individual of the proper age for a Regional Ileitis, having been sick for over a week, suffering with more or less abdominal pain accompanied by diarrhea with some blood which might be sufficient data to raise the question of a Regional Ileitis and if the X-ray had been at all suspicious of obstruction, a definite diagnosis might have been made even so far as locating the lesion at the terminal ileum.

Clinical Typhoid Fever was naturally the first condition considered, being the diagnosis on admission as well as the provisional diagnosis after admission. When it was found that typhoid was probably ruled out by tests

Continued on page XII

The President's Page

To the Members of the Maine Medical Association:

As this page must be in by June 15th, I cannot comment on the annual meeting other than to state that, owing to the good work of the Scientific Committee, it should be an excellent one.

The past year has brought up a number of difficult problems which have been met successfully under the able leadership of President Bunker.

There are still problems, however, which we shall have to meet.

Probably the most critical situation that the medical profession of this Country has ever faced is produced by the proposed legislation in Washington, the Wagner Health Act.

I recently listened to a magnificent address on this subject by the President of the American Medical Association, and after hearing the report of our delegate, Doctor Ellingwood, and the address of Doctor Fishbein at our banquet, we should all know more about it than we do now.

This page proposes to comment on various phases of this situation from time to time, and I would earnestly recommend that we all inform ourselves as thoroughly as possible.

I am looking forward with a great deal of pleasure to visiting the various county societies, to meeting old, and, I hope, new friends.

I ask for the active interest and coöperation of all in the affairs of our Association.

George L. Pratt, M.D.,
President, Maine Medical Association.

George Loring Pratt, M. D.

In our present chaotic world-wide political, social and economic unrest, it is indeed significant of true Americanism that the Maine Medical Association has chosen as its president, Doctor George Loring Pratt of Farmington; a man symbolic of our institution, lovable, philosophical, judicial and considerate—attributes nurtured through years of service in his own community—needs no further introduction.

Oldest son of Rev. J. Loring and Lucy Church Soule Pratt, he was born in the Town of Strong, June 17, 1877. He attended the public schools in Strong and Farmington and received his higher education at Bowdoin College, obtaining his A. B. Degree in 1901 and Medical Degree in 1904. While at Bowdoin he became a member of the Delta Upsilon Fraternity, captained the baseball nine, played football and assisted Dr. Whittier in the gymnasium and laboratory. During the period of his internship at the Maine General Hospital, during the year 1905, he joined the Maine Medical and American Medical Associations; after which he returned to Farmington where he has since resided and practiced.

The year 1909 witnessed three important steps in the progress of this lover of humanity. His marriage to Ethel M. Stein of Winthrop; membership in the newly-organized Franklin County Medical Society, which he has served for twenty-seven years as Secretary, and as President one year; and his appointment as Medical Examiner of Franklin County, which position he still holds.

He belonged to the National Guard and Medical Corps; served in the Army during the World War as Captain of the Medical Corps, with the 26th Div., A. E. F., until March, 1919.

Since the establishment of the Franklin County Memorial Hospital in 1929 he has tirelessly given his knowledge, energy, and ability by serving on its surgical staff; has served for two terms as Councilor for the Maine Medical Association; and has been Secretary of the Maine Medico-Legal Society since 1936.

His favorite pastime is playing Contract Bridge at the Masonic Club, of which he is a member. Here one is privileged to listen to his ready wit and philosophical outlook on life.

Every ready to assist, never forward, ever helpful, never boastful; it gives pride and satisfaction to the Members of the Franklin County Medical Association, that their first member to be chosen President of the Maine Medical Association should be Doctor George Loring Pratt.

Charles W. Bell.

Thomas Albert Foster 2nd, M. D.

Our president-elect is Thomas A. Foster 2nd, for history records that his grandfather, after whom he was named, was a leading physician in these parts from 1859 to 1896 and that he served as "recording secretary" of this Association from 1862 to 1864, as treasurer from 1864 to 1878, and as president in 1884-1885. He had two sons, both of whom practiced in Portland, — doctors Barzillai B. and Charles W. Foster. The former also was our president in 1907-1908 and was our "Tom's" father.

As for the president-elect himself, he was born, graduated from the Portland High School, from Dartmouth College and from the Harvard Medical School, all in due course of time. There followed a two-years' internship at the Hartford Hospital before serving with British Hospital Number Twenty-two in 1916 and with the American Ambulance Hospital at Neuilly, France, in 1917. The next year was spent with the United States Medical Corps and then came the establishment of an office in Portland for the practice of Pediatrics.

Ever since, Doctor Foster has been most active in the practice of his profession, having devoted much of his time to the care of children on the medical services of both the Children's and Maine General Hospitals, of both of which services he now is the Chief.

The Association is to be congratulated upon having once more displayed good judgment in the selection of a president-elect. This office and that of president are no sinecures; on the contrary, they impose upon their incumbents a heavy responsibility in these days of social unrest, when Medicine is at the "Cross Roads," as it were, and these men have the right to ask for and to expect the active, intelligent coöperation of every member of the Association in the solution of their difficult problems. Let us not as privates in the ranks be found wanting.

We extend cordial greetings and hearty congratulations to Doctor Foster. Moreover, we congratulate ourselves, for he, with "the social smile and sympathetic tear," is abreast of the times in medical-sociology even as he is in medicine. A man of good character, sterling qualities, excellent disposition and some spirit on occasion. His motto seems to be "give every man thine ear but few thy voice." Not a bad motto for a president-elect.

E. W. G.

Editorial

The Wagner Health Bill

Any bill of the magnitude of the one bearing the name of the Senator from New York, now before the Senate, seriously concerns not only the profession of medicine but every other profession, every other business and the people of this nation individually and collectively. What a national health bill proposes, what it will accomplish and how, who will CONTROL it and what it will cost, should not be a matter of conjecture and doubt by the profession that will have to work under its provisions and the taxpaying public that must provide the money to pay for it. An analysis of the importance and seriousness of this proposed program must be provided and made available to the public. It has been intimated in no uncertain terms, that the present system of medical care in the United States is inadequate; that the system under which the health and welfare of the people is taken care of is wrong, despite the fact that it has given the people of this country the lowest death rate and the longest span of life of any country in the world, and the only thing to do is to install a politically controlled medical service.

Certain facts regarding such far-reaching legislation, as the proposed bill of Senator Wagner as it now appears, must come from the profession of medicine. To aid in this purpose a physicians' committee, working in alliance with the National Committee to Uphold Constitutional Government, has been formed. The men on that committee warrant our support and confidence. Many of them hold important official positions in our National and State Associations. The president-elect of the American Medical Association, Dr. Van Etten, is on the committee from the State of New York, and we note with pleasure the names of Roger I. Lee, Trustee of the American Medical Association, and Creighton Barker of New Haven. The competency and honesty of purpose of this committee is beyond doubt or question; most emphatically the profession is not engaged in any political fight or argument, but it intends most properly to present to the public and to the entire profession the facts and the seriousness of the legislation proposed by Senator Wagner. We know what a politically controlled practice of medicine will mean; the public doesn't, but that information can and must be furnished. It is the duty of every single practitioner to become familiar with the dangers of centralized control of medical practice. It is also his duty to explain to his patients and friends the necessity of the practice of medicine being controlled by those competent to have valid opinions.

It is extremely well that the profession and the public recall the methods employed in obtaining the recent indictment against the American Medical Association. Certain officers and members of the Association were accused of infringing the anti-trust laws in a criminal manner. The Assistant Attorney-General of the United States released to the press, with resulting widespread publicity, statements implying the guilt of the Association. One of his assistants is reported to have made statements from public platforms that the Association and its officers were criminally guilty before the hearings were held by the Federal Grand Jury. Withdrawal of Income and Social Security tax exemption, on the grounds that the Association is not a non-profit scientific educational foundation, is threatened, hence it may be reasonably asked whether the present bill of Senator Wagner is not a natural sequence of the vast and far-reaching propaganda directed against the profession of medicine through the American Medical Association. It can hardly be said that a national emergency exists demanding the passage of the Health Bill of Senator Wagner or, in fact, any health bill. If grants are to be made by the Federal Government to aid in the care of the needy in any State, surely the fact that such need exists must and should be determined. Resistance to this proposed legislation is based

on the fact that its need has not been shown to exist; that the bill as drawn is vague and presents a "set-up" that beyond rebuttal incurs Federal control, but it is a most encouraging fact, as expressed in an Editorial in the *Journal of the American Medical Association*, June 10, 1939, that the sub-committee of the United States Senate appeared greatly impressed with the data presented by the American Medical Association.

"Not only can the national health and welfare problems be solved readily by the states without guidance from Washington, if the national economic policies are adapted for the purpose of creating regular jobs for regular wages, but every other problem of human relations now agitating the bosoms of our zealous reformers in Washington, will likewise be simplified. The problems of social security, taxation, labor-capital relations, defense against 'isms' and European ideologies will, under a program of industrial recovery, reduce themselves to simple, common sense American proportions." Carl E. M'Combs, M. D. *Journal of the Connecticut State Medical Society*. Vol. three, number five.

Report of the Delegate to the American Medical Association

The ninetieth session of the A. M. A. was held in St. Louis, Mo., May 15-19, 1939. The headquarters was located in the Statler Hotel.

The Standing Committees had arrived several days in advance; reports had been made ready for presentation, and every detail which had to do with the 1939 session had been attended to. Time and place had been arranged, not only for the 16 divisions of medicine and surgery on the regular program, but for scientific demonstrations, motion pictures and talks, also for subjects to be discussed in Scientific Assembly.

The House of Delegates of the A. M. A. was called to order by the Speaker, Dr. H. H. Shoulders of Nashville, Tenn., on Monday, May 15th, at 10.00 A. M. After the usual order of business and the Speaker had presented his list of reference committees, the reports of the Standing Committees were read and referred to the proper committee for approval.

Secretary West reported on May 1st the membership of the A. M. A. was 113,113 as compared with 105,406 in 1937 and 109,435 in 1938.

164 of the 177 Delegates were present at the opening session, including representatives from Canada, New Zealand and Australia.

Several of the American Boards held examinations preceding the meeting. Doctors F. T. Hill and S. Judd Beach are on the board of examiners of the American Board of Laryngology and the American Board of Ophthalmology respectively.

On Tuesday, May 16th, the third Symposium on Health in Education, under the sponsorship of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, together with the Section on Pediatrics, the Section on Preventive and Industrial Medicine and Public Health, the Section on Ophthalmology and the Section on Laryngology, Otology and Rhinology of the American Medical Association was held with Dr. S. Judd Beach of Portland, Maine, presiding.

Scientific Exhibits

Fifteen sections of the Scientific Assembly sponsored section exhibits under the guidance of specially appointed exhibit representatives, and an attempt was made to correlate the exhibits with the section programs.

At the request of the Committee on Scientific Exhibit of the Board of Trustees there were two special exhibits this year. The Special Exhibit on Anesthesia occupied five spaces. Demonstrations were given, motion pictures were shown and pamphlets distributed. The Special Exhibit on Fractures occupied six spaces with continuous demonstrations through the week.

Diabetes

Much interest was shown in the showing of the film "The Education of the Diabetic" in addition to which practical talks were given from 10.00 A. M. to 5.00 P. M. by Doctors Elliott P. Joslin, Endocrine Relations; H. F. Root, Diabetic Coma; Priscilla White, Pregnancy and Diabetes; W. H. Olmsted, Arteriosclerosis and Diabetes; Richard Wagner, Juvenile Diabetes. Also questions and answers.

There were 217 scientific exhibits which offered the same opportunities for post graduate study as were given in the exhibit on Diabetes.

In the general meeting 250 papers were read, 230 of which were supplemented by lantern demonstrations or moving pictures.

The Technical Exposition

Almost an acre of space was occupied by the exhibit of 250 firms. Manning the exhibits were 1,200 representatives, men and women technically trained in their particular lines. Many of them scientists in their own right, some of them inventors, some of them doctors of medicine or science.

Following a survey by The Commentator, the morning paper headlines the story of the meeting, "A World's Fair of the Medical Industry."

Summary Report

Board of Trustees

Within the last few years, many problems of the most important interest to medicine have demanded earnest consideration by medical organizations. Some of these problems have been brought up more acutely because of the activities of various agencies outside the medical profession that are most largely concerned with political considerations or because of long continued economic disturbances. The existing situation is one that has created tremendously larger demands than ever before on the time and effort of the officers, official bodies and administrative personnel of the A. M. A. Present indications are strongly to the effect that even greater demands will be made on the Association in future years and it is reasonable to expect that further expansion of the Association's facilities will be required.

Business Operations

Gross income from all sources for the year ending December 31, 1938, amounted to $1,758,147.09. Total expense for the year amounted to $1,769,548.60, an increase of $136,481.68 over the total expenditures for the year 1937. The net loss for the year was $11,401.51.

Payments received for Fellowship dues and subscriptions amounted to $655,875.91. Total receipts from the sale of advertising space amounted to $875,367.43. Income received from interest on investments was $86,857.26 and through the sale of securities the sum of $2,831.25 was realized.

Auditor's Report

Litigation pending against the Association amounts to the sum of $4,750,000.00.

Possible liability in respect to Federal Social Security Taxes amounting to $90,000.00 is also pending. The Association has appealed to the Bureau of Internal Revenue for reconsideration of a ruling made on April 28, 1938, classifying the Association as a business league, to reclassify it as a scientific and educational organization.

Group Hospitalization

Policy Established by House of Delegates

In June 1937, the House of Delegates recommended that the contract benefit provided by group hospitalization insurance should be limited to the room, bed, board and nursing facilities ordinarily provided by hospitals, and routine medicines. In regard to certain benefits offered by many hospital insurance plans, combining professional and technical services, your reference committee is in complete sympathy with those who would make every possible provision to prevent inclusion of any and all types of service involving medical care.

At the session of the House of Delegates in San Francisco (1938) the following was recommended:

If for any reason it is found desirable or necessary to include special medical services

such as anesthesia, radiology, pathology or medical provided by outpatient departments, these services may be included only on the condition that specified cash payments be made by the hospitalization organization directly to the subscribers for the cost of such service.

At this session (1938) the House of Delegates recommended that a joint study be made by the Council on Medical Education and Hospitals and the Bureau of Medical Economics to determine the existing relations between hospitals and the physician practicing therein. This study was to be undertaken with a view toward a clearer definition of the relationships in the departments of anesthesia, radiology, pathology and physical therapy in order that ethical standards may be established for the practice of physicians in hospitals which would prevent the exploitation of either the public, the hospitals or the physicians.

At the last meeting of the House of Delegates, in San Francisco, a resolution was introduced declaring that the serving of members of the American Medical Association on the faculties of schools of chiropody is unethical. The cause of the introduction of the resolution was a statement made in the annual report of the Judicial Council for that year that "teaching in cultist schools and addressing cultist societies is even more reprehensible" than association with cultists in practice. The resolution was referred to the Judicial Council as a reference committee and on its recommendation the resolution was laid on the table. Since that meeting the Council has investigated the matter further and is of the opinion that the practice of chiropody is not a cult practice as is osteopathy, chiropractic or Christian science, which have bases of treatment not supported by scientific or demonstrated knowledge but on which bases all diseases are treated. Chiropody is rather a practice ancillary—a handmaiden — to medical practice in a limited field considered not important enough for a doctor of medicine to attend and therefore too often is neglected. General opinion seems to be that chiropody fairly well satisfies a gap in medical care that the profession has failed to fill. There are several reputable medical colleges whose faculties teach this branch of the healing art to students who later become chiropodists and the Council can see no reason to declare such teaching by members of this organization to be unethical, provided the schools in which they teach are connected with approved schools of medicine and recognized standards of premedical education are required.

Medical Fee Schedules

The necessity for or the advisability of such schedules has never been considered by House; and

Whereas, It has been an unwritten rule, established by a long line of ethical practitioners, both past and present, to adapt charges for medical services to the ability of his patient to pay, untrammeled by fixed community schedules; therefore be it

Resolved, That this device, appearing with increasing frequency, be examined by an appropriate agency of the A. M. A. to the end that the Association may declare itself on certain controversial points, among which are:

(a) The advisability of or necessity for fee schedules in the public interest.

(b) Their ethical or unethical qualities.

(c) Necessity for certain fixed principles to guide constituent units of the Association when and if it is deemed, in the public interest, necessary to adopt such a device, and

(d) Whether such schedules, approved by the constituent units of the Association should or should not provide for elasticity so as to permit of adaption to wage levels, specialized medical services, variations based on differential costs as between urban, semi-urban and rural practice.

Summary Report

Council on Pharmacy and Chemistry

Important legislation enacted by Congress during the year 1938 included a bill regulating the advertising of foods, drugs and cosmetics outside the package, over the radio and through newspapers, the act providing for more effective control over the supervision of

labeling and advertising accompanying packaged products and requiring the disclosure of the contents of the preparations.

The law now recognizes and provides for pronouncements of expert medical opinion, and it is possible that the official opinions of the Council on Pharmacy and Chemistry may have some important influence in aiding in the formulating of decisions on the use of therapeutic agents.

All provisions will become effective June 25, 1939.

Under the provision of a law enacted by the Seventy-Fifth Congress, osteopaths are given the same status as doctors of medicine under the United States Employees' Compensation Act.

The Committee on Medical Care recommended a special study of free service rendered by physicians and dentists throughout the United States. 496,000 records were prepared and distributed.

As of February 28, 1939, 416 county medical societies in thirty-six states had completed the study and returned to the Bureau of Medical Economics the Summary Sheets with information obtained.

Medical societies in forty-five states and the District of Columbia are participating in the Study of Medical Care, and it is expected that an additional number of medical societies will complete the Study at a later date.

The Committee on Scientific Research

Believes that its work should be continued and recommended that the same appropriation be made for 1939 as for 1938; namely, $12,500.00 for grants in aid of medical research and $1,200.00 for expenses of the committee.

Council on Medical Education and Hospitals

Ray Lyman Wilbur, Chairman, J. H. Musser, Fred Moore, Reginald Fitz, Fred W. Rankin, Charles Gorden Heyd, Frank H. Lahey, William D. Cutter, Secretary.

Owing to the pressure of extra work created by the National Health Conference last July and by the indictment of the Association by a grand jury of the District of Columbia, the Council was not in a position to make a complete report but an agreement has been reached with a representative group of radiologists as to a definition of the function of the radiologist in the hospital as follows:

The responsibility for all radiologic examinations must rest on the physician-roentgenologist who is head of the department. His findings and conclusions for all examinations should be placed in the patient's chart. Nothing in this provision should preclude additional study and interpretations by qualified attending physicians on the staff.

Essentials of Approved Residencies and Fellowships

Approved residencies and fellowships are offered in thirty branches of medicine.

Two new departments having created American Boards of Certification have been added to this list. The department of radiology and the department of anesthesiology.

After January 1, 1942, an applicant for certification by the American Board of Radiology must have completed a period of study after the internship of at least three years in a recognized institution or radiologic department. The period of specialized training should include an active experience of not less than twenty-four months and graduate instruction in pathologic anatomy, radio physics and radiobiology. Board certificates are offered in (1) the entire field of radiology, (2) roentgenology, (3) diagnostic roentgenology and (4) therapeutic radiology.

Anesthesiology—After January 1, 1942, the requirements for certification by the American Board will be interpreted as three years of special training and three years of additional practice in anesthesiology. It is expected that each graduate student should administer a minimum of 500 anesthetics a year, of which 400 should be general surgical in type.

All laboratories should be under the supervision and direction of a physician licensed to practice medicine in the state.

At the Congress on Medical Education and Lincensure, the registration this year was 550, a larger attendance than at any time within the last ten years.

Through the Social Security Act, the fed-

eral government has made available several million dollars for the further training of physicians. A number of state societies have found it possible through the coöperation of the state department of health, to direct the expenditure of this money and to strengthen their own programs of postgraduate education. In other states the health department has inaugurated independent courses with results not altogether satisfactory. The Council feel that the House of Delegates might well bring to the attention of each of the constituent societies of the Association the paramount importance of retaining control of this phase of professional education.

Total registration, 7,412.

2,534 in the Section of Medicine
1,265 in the Section of Surgery

9 registered from Maine
107 registered from Massachusetts
7 registered from New Hampshire
29 registered from Connecticut
4 registered from Vermont
7 registered from Rhode Island

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The proceedings of the St. Louis Session are printed in detail in the *Journal of the A. M. A.*, May 27, 1939. It is my wish that every member read it, that they may appreciate the amount of time and work the officers and committees give to your organization. The report of the Committee on Medical Care, Dr. W. F. Braash, of Rochester, Minn., Chairman, is of extreme importance at this time when every practicing physician is confronted with political and lay interests in the Health and Welfare of the Public.

I think we are all cognizant of the fact that the Wagner Bill is not to be overlooked. At the special meeting of the House of Delegates held in Chicago, September, 1938, a special committee was appointed to meet with the presidents' interdepartmental committee in Washington. This conference was very unsatisfactory. Again at this session held in St. Louis the same committee was delegated to meet with a subcommittee of labor and education on May 25, 1939, and explain the Resolutions on Opposition to the Wagner Bill as approved by the House of Delegates of the American Medical Association.

The A. M. A. is exceptionally fortunate in having had as its President, Dr. Irvin Abell of Louisville, Ky., and again it is fortunate in having Dr. Rock Sleyster of Wauwatosa, Wis., at this time who with the exceptionally fine and experienced committee under the chairmanship of Dr. E. H. Cary of Dallas, Tex., will save "organized medicine."

For further and more detailed information on the subject I now invite you to come to the annual banquet of the Maine Medical Association to be held on Tuesday evening, June 27, 1939, at the Poland Spring House, and listen to the guest speaker, Dr. Morris Fishbein of Chicago, Editor of the *Journal of the A. M. A.*

You all know how fast he must write, but you will never know how fast a man can talk until you have heard him, and when he talks he says plenty.

Respectfully submitted,

Wm. Ellingwood, M. D.,
Delegate to A. M. A.

In carcinoma of the ovary we have what I believe is the one exception to the time-honored axiom "once inoperable, always inoperable." Several patients explored and closed as hopeless have been treated palliatively by external irradiation, repeatedly tapped, and, one or two years later, reoperated and the bulk of the devitalized tumor removed with recovery for a period of years.—Frank H. Smith, M. D., *The Am. Jour. of Roentgenology and Radium Therapy,* June, 1938.

The fact that pure Krukenberg tumors are always secondary to carcinoma elsewhere should make this tumor as important to the gastro-enterologist as to the gynecologist. The gastro-intestinal tract should be examined at every operation for ovarian tumor. The primary growth is sometimes so small, however, that its presence cannot be determined at operation, regardless of careful search.—Angeline Simecek, *The Am. Jour. of Cancer,* September, 1937.

Nominating Committee Report

The Nominating Committee, composed of Drs. Forrest B. Ames, Chairman, J. C. Oram, S. H. Kagan, E. M. McCarty, H. L. Appollonio and R. Bliss, made the following report at the Second Meeting of the House of Delegates, June 26, 1939, at Poland Spring, Maine.

STANDING COMMITTEES

Scientific Committee

Merrill F. S. Greene, Lewiston, Chairman.
H. C. Scribner, Bangor.
Mortimer Warren, Portland.
C. C. Weymouth, Farmington.

Committee on Medical Education and Hospitals

Adam P. Leighton, Portland, Chairman.
Thomas A. Foster, Portland.

Medical Advisory Committee

Carl M. Robinson, Portland, Chairman.
Allan Woodcock, Bangor.
George E. Young, Skowhegan.
Willard H. Bunker, Calais.
C. Harold Jameson, Rockland.
Frank H. Jackson, Houlton.
Forrest B. Ames, Bangor.
The Secretary, ex-officio.

Legislative Committee

The President, ex-officio, Chairman.
The President-elect, ex-officio.
R. V. N. Bliss, Bluehill.
Warren Steele, Lewiston.
N. H. Nickerson, Greenville.

Public Relations Committee

Warren E. Kershner, Bath, Chairman.
Frederick T. Hill, Waterville.
H. C. Knowlton, Bangor.
C. W. Kinghorn, Kittery.
W. A. Ellingwood, Rockland.

Cancer Committee

Forrest B. Ames, Bangor, Chairman.
Magnus Ridlon, Bangor.
E. H. Risley, Waterville.
William Holt, Portland.
B. Beliveau, Lewiston.

Committee on Social Hygiene

E. S. Merrill, Bangor, Chairman.
B. B. Foster, Portland.
C. B. Popplestone, Rockland.

Publicity Committee

Thomas A. Foster, Portland, Chairman.
The Secretary, ex-officio.

SPECIAL COMMITTEES

Committee on Nursing Affairs

B. L. Bryant, Bangor, Chairman.
Stephen S. Brown, Portland.
George A. Tibbetts, Portland.

Tuberculosis Committee

George E. Young, Skowhegan, Chairman.
Lester Adams, Hebron.
Walter Gumprecht, Bangor.

Committee on Investigation of Collection Agencies

E. W. Gehring, Portland.

Advisory Committee on Syphilis Control

B. B. Foster, Portland, Chairman.
Carl E. Blaisdell, Bangor.
A. H. Morrell, Augusta.

Committee on Prevention and Amelioration of Deafness

Harry Butler, Bangor, Chairman.
P. J. Mundie, Calais.
George O. Cummings, Portland.
W. A. Ellingwood, Rockland.
Wm. H. Chaffers, Lewiston.

Committee on Problems of Health Insurance and State Medicine

Warren E. Kershner, Bath, Chairman.
Frederick T. Hill, Waterville.
Howard Apollonio, Camden.

Committee on Graduate Education

Frederick T. Hill, Waterville, Chairman.
Julius Gottlieb, Lewiston.
Frank H. Jackson, Houlton.
Eugene E. Holt, Portland.
L. H. Smith, Winterport.

Committee on Maternal and Child Welfare

Roland B. Moore, Portland, Chairman.
A. W. Fellows, Bangor.
C. S. Bauman, Waterville.
G. W. Twaddle, Lewiston.

Delegate to A. M. A.

William A. Ellingwood, Rockland (two years).

Resolution

At the 87th Annual Meeting of the Maine Medical Association held at Poland Spring, Maine, June 25th, 26th, and 27th, the House of Delegates in session June 26th, voted to accept the following resolution as presented by George L. Pratt, M. D., of Farmington, and approved by the Council.

Resolved: That, in the opinion of the Maine Medical Association, The Wagner Health Act proposes a revolutionary change in the practice of medicine, which is not justified by reliable evidence; that the cost of the proposed legislation would be tremendous and indefinite;

That it is impossible to amend the Act so as to make it workable; that our Senators and Representatives in Washington be informed that the Maine Medical Association urges them to oppose the passage of the Act.

Report of the Special Committee Appointed to Confer with Committees from the Maine Hospital Association and Maine Nurses' Association to Consider the Problem of Nursing Education in Maine

To the Officers and Members of the Maine Medical Association:

Your Special Committee appointed to confer with committees from the Maine Hospital Association and Maine Nurses' Association regarding the problem of Nursing Education in Maine begs leave to submit the following report.

The three committees met in conference and took the following action:

It was voted that a subcommittee from these three committees study the relative cost of graduate and student nursing service in hospitals in Maine. As the result of a questionnaire sent to every hospital in Maine, it was generally agreed that it is more economical and satisfactory to both patient and hospital to use graduate nurses in hospitals of less than fifty beds, and to employ the training school method augmented by graduate nurses for hospitals of more than fifty beds. It was universally agreed that the present standards of nursing education be maintained. No one expressed a desire to lower these standards. Only five hospitals replying to the questionnaire stated they had any difficulty in securing graduate nurses.

It was also voted that a subcommittee study the present status of nursing education in Maine and recommend future policies. This subcommittee has as yet rendered no report.

Respectfully submitted,

Frederick T. Hill,
Chairman.

County News and Notes

Aroostook

The annual June meeting of the Aroostook County Medical Society was held at the Northland Hotel, Houlton, on June 20th, with about thirty members in attendance.

After a six o'clock banquet, served in the Silver Room, the business meeting was opened by Dr. Oscar Norell. Matters pertaining to post-graduate work were discussed and the election of officers was held. The following officers were elected for the coming year:

President—W. V. Kirk, Eagle Lake.
Vice-President—A. T. Whitney, Houlton.
Secretary-Treasurer—T. G. Harvey, Mars Hill.
Board of Censors—F. Gregory, H. C. Kimball and P. L. B. Ebbett.
Delegates to the Maine Medical Association—A. B. Hagerthy and H. E. Small.
Alternates—Storer Boone and Oscar Norell.

The first speaker of the evening was Dr. T. G. Harvey of Mars Hill, who gave an interesting review of his recent post-graduate work in Boston at the Bingham Foundation and outlined the modus operandi of the clinic. He then spoke on infant feeding, bringing out many scientific and good points in favor of breast feeding. Particularly interesting were the figures of one of his Professors recently emigrated from Germany who believes that the continuation of a pregnancy is not contra-indicated in pulmonary tuberculosis. It was the Doctor's opinion that the various commercial infant foods were not necessary except in rare cases; milk from mixed herds is best; frequency of feedings is dependent on the baby, and he summarized his speech and analyzed the ingredients of the various infant foods.

The guest speaker of the evening was Dr. Arthur Van Wart. He spoke on the subject of "Medical Economics." He compared the private practice of years past with the numerous State, clinic and governmental encroachments of the present time. He gave the premise that the medically indigent must be cared for and so analyzed and compared the two logical approaches of (1) "State Medicine" or (2) "Health Insurance." At this point Dr. Van Wart interrupted his paper for a round table discussion and Dr. Frank H. Jackson in opening the same outlined the situation in the United States, and urged all physicians to acquaint themselves with the Wagner Health Act. Dr. Van Wart then reviewed the health systems of Germany, Belgium and Russia, and these were found to be unsatisfactory to both physician and patient. He then sketched the advantages and disadvantages of health insurance. From his paper and the prolonged informal discussion following it was obvious that Dr. Van Wart had given considerable time and thought to the subject.

Dr. Arthur T. Whitney then spoke briefly on the Farm Security Administration as pertaining to the medical group of Aroostook County and it was voted to adopt the offer as set forth some time previously. There was very little discussion until the Society has some active participation in the plan.

It was then voted to hold the October meeting at Mars Hill, Maine.

The meeting was adjourned at 11.15 P. M.

Respectfully submitted,

ARTHUR T. WHITNEY,
Secretary.

Cumberland

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, Tuesday evening, May 2nd, at 8.15 P. M. Twenty-nine members and one guest were present.

Dr. O. H. Cox was elected to membership.

Resolutions on the death of Dr. E. S. Cummings were adopted by the Club.

A committee consisting of Dr. E. A. Greco, Dr. J. C. Oram and Dr. J. F. Wellington was appointed to arrange for the Annual Outing in June.

The paper of the evening was by Dr. Benjamin Zolov, who spoke on *Sulfapyridine and Sulfanilamide in the Treatment of Pneumonia.* He gave a summary of 40 cases of pneumonia treated at the Farrington Hospital. The paper was discussed by Drs. E. R. Blaisdell, D. H. Daniels, E. A. Greco, C. B. Sylvester, R. S. Hawkes, T. C. Bramhall and F. A. Ferguson.

ALICE WHITTIER, *Secretary.*

Knox

A meeting of the Knox County Medical Association was held at the Copper Kettle, Rockland, Maine, June 8, 1939. The meeting was called to order by Dr. Apollonio, President.

Notes of the last meeting were read and two applications for membership were discussed and referred to the censors.

It was voted that the Secretary write to Mrs. Leijonborg of Liberty, expressing the sympathy of the Association in the death of Dr. Frans Leijonborg.

Plans for the August meeting were discussed, and it was left to the President to select the place.

Dr. Carswell reported on the adjustment of the Camden Hospital situation.

Dr. Ellingwood reported the proceedings at the American Medical Association meeting at St.

Louis, and the interest shown by the large attendance of delegates.

The possibility of a meeting of the Maine Medical Association at Rockland was speculated on, and Dr. Ellingwood appointed to serve as a one-man committee.

Mr. Henderson, who was to talk on "Old Age Assistance as Relating to the Medical Profession," was unable to appear, but Dr. Lawrence of Boston spoke on "The Disturbances of the Menopause," and everyone was vitally interested and discussed the subject thoroughly. Drs. Jameson, Soule, Brown, Greene, and Ellingwood brought up matters of interest.

The meeting was then adjourned.

Respectfully submitted,

A. J. Fuller, M. D.,
Secretary.

Oxford

The regular meeting of the Oxford County Medical Society was held at Bethel Inn, Bethel, Maine, Wednesday, May 24, 1939.

One new member elected to membership and one reinstated.

Movies on *Eclampsia*, from the Maine State Health Department, were presented by Dr. G. G. Defoe.

A very interesting paper on *Observations Concerning Heart Failure* was given by Dr. Eugene H. Drake, Portland, Maine

About twenty-five members attended a fine banquet at the Bethel Inn.

J. S. Sturtevant, M. D., *Secretary.*

Piscataquis

A meeting of the Piscataquis County Medical Association was held at the Braeburn Hotel in Guilford on May 25th.

It was voted that a meeting be held at Moosehead Lake some time this summer, to which the Somerset, Penobscot, Kennebec and Aroostook County Medical Societies should be invited.

Allan Woodcock, M. D., of Bangor spoke most interestingly on *Fractures of the Femur*. He clearly explained the proper use of Russell Traction, also the use of Skelatol Traction.

Respectfully submitted,

Norman H. Nickerson, *Secretary.*

Washington

The May meeting of the Washington County Medical Society was held at Dr. J. C. Bates' residence, Quoddy area, Eastport, on May 25, 1939.

The meeting was called to order by the Vice President, P. J. Mundie of Calais. Minutes of last meeting were approved as read. A short business session followed.

The first paper on the program, entitled "Epigastric Surgery," was given by Harrison L. Robinson, M. D., of Bangor.

The second paper, "Physiotherapy," was delivered by Harold Pressey, M. D., of Bangor.

A long discussion followed. Those taking part were: Doctors Miner, Hanson, Bates, and Larson.

A Buffet Lunch followed the meeting.

Those present were: Doctors Metcalf, Mundie, Bunker, Miner, Bates, Gilbert, Hanson, Bennet, Burritt, Cobb, Crane, Norris, Larson, Robinson, and Pressey.

The Society wishes to thank Dr. Bates of the Quoddy Hospital and Mr. Harry Gilson, Director of the National Youth Administration at Quoddy, for the use of their buildings, and entertainment.

Oscar F. Larson, M. D., *Secretary.*

New Member

Oxford

Beryl M. Moore, M. D., Oxford.

Removal Notices

W. H. Kelley, M. D., announces his removal from Sanford, Maine, to 26 South Street, Biddeford, Maine.

Carl M. Robinson, M. D., announces his removal from 181 State Street, Portland, Maine, to 31 Deering Street, Portland, Maine.

Coming Meeting

Notice

The Piscataquis County Medical Society invites the members of Somerset, Aroostook, Penobscot and Kennebec County Medical Societies to a joint meeting at the Squaw Mountain Inn, Greenville, Maine, Wednesday, July 19, 1939, to which the ladies are invited.

Dinner at 1.00 P. M. (Daylight Saving Time).

Allan Woodcock, M. D., Bangor, Maine, will conduct a panel discussion on "Fractures."

George L. Pratt, M. D., Farmington, Maine, our newly-elected President, will be present.

A cordial invitation is extended to all members of the State Association.

This has been an outstanding mid-summer meeting for several years and it is hoped that we will have a good attendance.

Necrologies

Henry I. Durgin, M. D., 1864-1939

Dr. Durgin died at his home in Eliot, June 15, 1939. Born at Freedom, Maine, April 21, 1864, he studied medicine for a time under Dr. J. E. Scruton of Union and then entered the University of Vermont, later attending the University of New York where he was graduated in 1889. He began his practice in Newfield, Maine, but shortly afterward moved to Eliot where he has been located since.

He was a member and past president of the York County Medical Society, a member of the Maine Medical Association and the American Medical Association. On June 8th he was presented with the Maine Medical Association's gold medal in recognition of his fifty years' faithful service.

Dr. Durgin was very prominent in fraternal circles and was a member of the Congregational Church.

He is survived by his widow, Mrs. Alta Knox Durgin, to whom he was married forty-eight years ago.

The vacant place that he leaves in our midst will be filled by the memories of generous services, sacrifices, and achievements. He was highly respected and deeply loved by all who had the good fortune to meet him.

Joseph J. Pelletier, M. D., 1880-1939

Dr. Pelletier, for thirty-eight years a practicing physician in Lewiston, died at his home, June 4, 1939.

Born at Berlin, New Hampshire, April 1, 1880, the son of Damas and Bridget Wheeler Pelletier, he received his preliminary education in the public schools of Lewiston and was graduated from Bowdoin Medical School in 1901. In 1905 he studied at Paris, London and Rome, and four years later at the University of Louvain, Belgium.

Dr. Pelletier was a member of the Androscoggin County Medical Society, the Maine Medical Association and the American Medical Association. He served four years as a member of the Lewiston School Board and had also served as city physician.

He was a World War veteran, having enlisted in the United States Army in September, 1917, and assigned to active duty in January of the following year with the rank of Captain.

He is survived by his widow, Rose M. Fisher Pelletier, to whom he was married in 1901, and a son, Dr. Anthony D. Pelletier of Lewiston.

Notices

American Board of Internal Medicine, Inc.

Written examinations for certification by the American Board of Internal Medicine will be held in various sections of the United States on the third Monday in October and the third Monday in February.

Formal application must be received by the Secretary before August 20, 1939, for the October 16, 1939, examination, and on or before January 1st for the February 19, 1940, examination.

Application forms may be obtained from Dr. William S. Middleton, Secretary-Treasurer, 1301 University Avenue, Madison, Wisconsin, U. S. A.

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*Tumor Clinics**

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 10.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital* — Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital — Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

State of Maine Board of Registration of Medicine

Adam P. Leighton, M. D., Secretary

Physicians licensed to practice medicine and surgery in Maine on March 15, 1939:

Through Examination

Helen W. Bane, M. D., Farmington, Maine.

Sidney Robert Branson, M. D., Passaic, New Jersey.

Ernest LaPierre Coffin, M. D., Bar Harbor, Maine.

Frederick Collins Dennison, M. D., Lynn, Massachusetts.

George Pierre Desjardins, M. D., Brunswick, Maine.

Walter Louis Henry Hall, M. D., Orono, Maine.

Lillian G. Moulton, M. D., Northboro, Massachusetts.

Alfred Oestrich, M. D., Rumford, Maine.

Julius Sherman, M. D., Mattapan, Massachusetts.

Frank Rocco Visceglia, M. D., Brooklyn, New York.

Through Reciprocity

Henry Almond, M. D., Rochester, New Hampshire.

Nicholas Famularo, M. D., Queens Village, L. I., New York.

Chester Winfield Malmstead, M. D., Bangor, Maine.

Book Reviews

"Clinical Gastroenterology"

By Horace Wendell Soper, M. D., F. A. C. P., St. Louis, Mo., with 212 illustrations.

Published by The C. V. Mosby Company, St. Louis, 1939. Price, $6.00.

This work is said to cover the field of gastroenterology with special emphasis on diagnosis and treatment. The reader is never burdened with disputable measures. Only remedial agents and methods which have been tried and found therapeutically efficient are recommended. Every chapter that demands illustration of the clinical situation is richly supplemented with appropriate X-ray prints. The author takes a rather radical view concerning milk, raw and pasteurized. He employs neither of them as dietary agents. In his experience, evaporated milk gave most satisfactory therapeutic results. There is an excellent chapter on the author's emetine treatment for amebic dysentery so successfully efficient that only one case out of 302 suffered from a recurrence; "emetine given as I have employed it is not toxic to the patient but is extremely toxic to the amoeba histolytica."

"Short Stature and Height Increase"

By C. J. Gerling. Published by Harvest House, New York, 1939. Price, $3.00.

In a rather light vein and easy style, the reader is sharpened up to admire the ideal he-man, about six feet tall, well proportioned and standing erect.

Every chapter, except the last one, reminds the short man that he is rather out of place and that he ought to try to feel, stretch, feed, drug, dress, build and think himself up to full man's size. Only after the uphappy undersized man has been told in several chapters in how many ways he may try to deceive himself and others into believing himself to be taller than he really is, are the blinds removed. In the very last chapter he is told what he already knew; namely, that after all, no one can really do very much about one's stature, and that after all, a great many of the world's famous men were and still are of short stature and are very successful in spite and because of it.

"Personal and Community Health"

By C. E. Turner, A. M., Sc. D., Dr. P. H.

Professor of Biology and Public Health in the Massachusetts Institute of Technology; Formerly Associate Professor of Hygiene in the Tufts College Medical and Dental Schools; sometime member of the Administration Board in the School of Public Health of Harvard University and the Massachusetts Institute of Technology; Fellow American Public Health Association; Chairman, Health Section, World Federation of Education Associations; Major, Sanitary Corps. U. S. A. (Reserve).

Published by the C. V. Mosby Co., St. Louis; 5th Edition, 1939. Price, $3.00.

This new edition is printed on eye-toned paper. The toning seems to consist of the addition of a small amount of blue coloring matter so that the reading surface presents a blue resembling the pale blue atmosphere of daylight. The gloss of the paper is reduced to a minimum. It has been said that the study of Hygiene is the same for any student regardless of where he studies. To study hygiene from Turner's new fifth edition, however, seems to be promising better results than some others, judging from the fact that Turner is the standard text in many colleges and universities. The book is planned to take care of the needs of various college-level groups and seeks to present the most essential knowledge of personal and community health which is in our possession at the present time. The text is based on instructions given for many years to students in schools of public health, medicine, dentistry, nursing, teaching, engineering, etc., and is still very well received everywhere.

The author seems to be inspired in his teaching and writing by the belief that only by persistent efforts at educating ourselves and each other to properly care for our living body in all spheres can we hope to retard the workings of the rule for mankind which works so persistently efficient for the animal world; namely, that death is the rule and life the exception. Man can learn to postpone disease and death considerably as our knowledge concerning causes for and prevention of health-impairing agencies accumulates.

"The Language of the Dream"

By Emil A. Gutheil, M. D. Published by The Macmillan Company, New York, 1939. Price, $3.50.

The employability of a term like "scientific" in regard to anything we do and think worth while urges us on in our goal-striving labors. The interpretation of dreams, thought speculative in ancient times, is now considered highly scientific. The science of the language of the dream, however, is not like the science of mathematics, for instance, though both are said to be founded upon a solid body of facts and well formulated principles. Modern dream analysis began with Freud about forty years ago. Since then, considerably more work has been done by Stekel, Adler, Jung, Rank, and many others. The author, who worked with Stekel for seventeen years, is convinced that there is great need for a new kind of book on dreams, one less lengthy than some and more instructive than others, one better suitable for American requirements. What he tried to do is to show as clearly and interestingly as possible that "Dream interpretation does not mean the successful application of a certain preconceived theory of the physician, but rather the discovery of mechanisms which give us a sufficient insight into the patient's specific and individual mental situation. The more we bring out of an individual dream, the more quickly and completely we can attain our aim: that of curing the patient."

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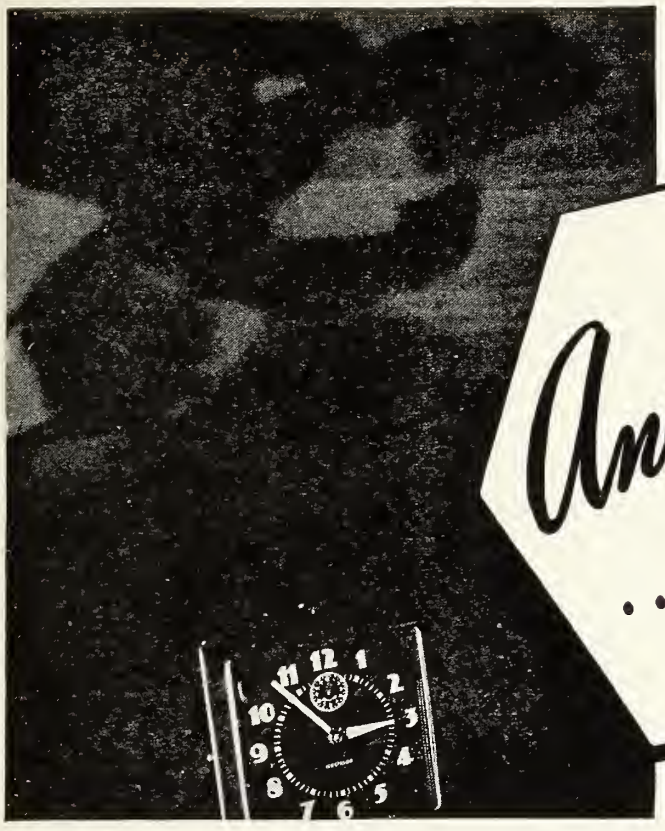

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Continued from page 172

and that the abdomen was probably a surgical problem, consideration was given to appendicitis as the underlying condition, but the findings were not consistent enough to make a definite diagnosis. After observation for a few hours there was not much doubt that the abdomen was the source of trouble and the most likely pathological process was a ruptured gangrenous appendix.

On opening an abdomen and finding Regional Ileitis there is a difference of opinion as to how the cases should be handled, as you note in the above case, the surgical procedure elected was that of resection with anastamosis.

Since the Regional Ileitis was at the terminal ileum and there was a good portion distal to the infected area and the entire area easily mobilized this seemed an extremely satisfactory case for a one stage operation. The patient did not, as reported, survive this procedure, but I believe a one stage operation if easily done is good surgery.

In those patients who are poor surgical risks and in those where there is difficulty in easily resecting the infected area, a two stage palliative measure first either doing an ileocolostomy or some type of intra-abdominal anastamosis and then later accomplishing the second stage, resection.

We must also recognize that a chronic form of Regional Ileitis does exist but our comments are only on this case of the acute form.

In operating upon a case of Regional Ileitis in the acute stage, we must not be content until we have inspected the entire intestinal tract for other similar lesions. A first stage ileostoma or an anastamosis would not accomplish what we wish and expect it to do if an area of regional involvement left above results in an obstruction.

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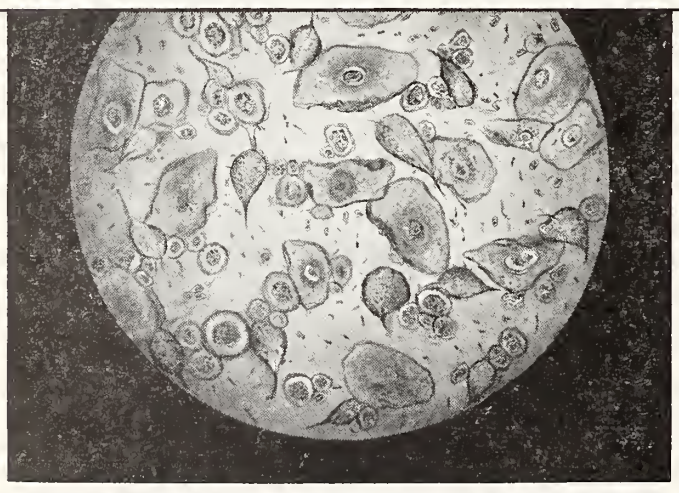

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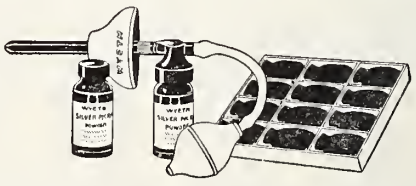

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*Medico-Legal Problems**

By A. Warren Stearns, M. D., Boston, Massachusetts.

There are many situations in which medicine and law impinge upon each other. While there is probably no function of the doctor which may carry with it higher altruism or greater social need than assisting the law, this function of medicine rarely leads to distinction and often to criticism. A brief discussion of this matter may not be out of place.

The theories of medicine and law are quite different. The doctor seeks the truth by a process of differential diagnosis. Arraying all the possibilities before him, he gradually eliminates those which have the weaker claim for consideration until finally the one having the least against it and the most for it survives. Medical diagnosis is always tentative and can be changed if new information is available. Legal theory, as I have known it, is quite different. The truth is conceived as the resultant in the conflict of two opposites. Let one side amass all the information tending to support its view, however partisan this may be, and let the other side do likewise, put them to a battle of words with a judge as the referee, and what survives is the truth. There is a finality about legal decision which is foreign to medical. I shall not debate the relative merits of these two methods except to say that I prefer the medical.

So, the doctor called upon to assist, is frequently, one might say usually, called in to help build up one partisan view of the case, and insofar as he does this he tends to lose his medical role or standing, and to adopt a partisan role, perfectly proper in the law but not so proper in medicine. Arising directly from this situation comes another, namely, the doctor's claim to impartiality or disinterestedness. There is a legal fiction which says that under certain circumstances the mind is impartial. I recall once when a man who had been defending insurance companies all his life and had been a bitter enemy to plaintiff lawyers and doctors, was elevated to the bench. I remarked to another judge that I thought it would be very hard for him to be impartial in a tort case with his background. The judge naively said, "Oho, but no, you do not understand. When one becomes a judge he lays aside all those things." One might as well say that he laid aside his whole life's work and his mind and his body as to say that laying aside a prejudice was an act of the

* Read before the Kennebec County Medical Society, at the Augusta State Hospital, Augusta, Maine, December 15, 1938.

will. And so it has always seemed to me absurd for a doctor to claim philosophic detachment. I have tried many times to do this, and of course, we should all struggle to do it. Nevertheless, we should not be blind, but should recognize that the mere employment of a doctor as a witness according to the fundamental reactions of human beings tends to make him become a partisan. Consciously or unconsciously his mind is inclined to favor the side upon which he is employed, and to look askance at that of the enemy. While every physician, in my opinion, should do his best to attain impartiality, let him not fool himself. Time and time again I have had to check my rising passions and say to myself that after all there are two sides to every question, and the other fellow may be right.

Another word of warning. From my observation it appears to me that the cases going to trial often represent a situation where the law is bound to give a decision on matters which are outside the border of scientific exactness. A doctor may procrastinate and may evade, he may even at times be so bold as to say, "I do not know," but the court has to make a decision. It has to say "yes" or "no." This often means that the doctor may properly give his best judgment in spite of inadequate data, but it ought never to take from him that glorious prerogative by which he may say, "I do not know."

Lastly, I wish to say that I have frequently been able to orient myself without offending a lawyer by saying to him, "My good friend, what I have to sell is advice, what you wish to purchase is service. Therefore we cannot do business together." So often the legal mind honestly enough wishes only assistance in winning his particular battle. Occasionally the doctor may be so employed, but usually the lawyer should come to the doctor, set forth his case and ask his advice concerning the matter. If that advice fits in with the needs of the lawyer, well and good. If it does not, the matter should end there. Again, while it may be perfectly good ethics for a lawyer to take a case on a contingent fee, a doctor should never agree in advance to have the payment of his fee, or its size, contingent upon a successful verdict. There may be worthy cases in which it would be improper for him to insist upon guaranteed payment or payment in advance, but he will be more free in his judgments if he takes the cases as they come, renders his regular bill and hopes, even if he does not expect that he may be paid.

With this preamble, let us run over briefly some of the situations in which the doctor's aid is sought in legal matters.

Criminal Responsibility

By far the most dramatic situation arising in court is a murder trial. Theoretically it is important to determine the responsibility of the meanest offender, and yet one finds criminal responsibility questioned very, very rarely except in murder trials. This matter has been dramatized by the press and has come down from antiquity as a big show.

From time immemorial the law has excused irresponsible persons from punishment. In order to be punishable the culprit must have a mens rea, that is, a bad mind. If he is suffering from mental disease he cannot have a bad mind and therefore he cannot be punished. Now in the ordinary run of affairs when an out and out insane person commits murder, it is usually obvious to everybody, and in most civilized communities they are committed to a mental hospital forthwith and that ends the matter. Likewise, there are other cases so utterly devoid of any possibility of an insanity defense that it is not raised. However, when there is no other defense it is usually possible to raise the question of the sanity of the culprit. It is likewise true that a great many murders are committed by borderline cases. The substantial, well-balanced good citizen is rarely brought to the bar of justice for murder. So it is the borderline case upon which medicine itself has often not made up a final judgment that is fought out in the courts. I suppose every condition which might affect one's mind has probably in the past been brought before the court as an excuse for murder, but they tend to fall into relatively few categories.

1. Psychoses.
2. Intellectually defective individuals.
3. Emotionally unstable, "Psychopathic personality" and "Constitutional inferiority."

4. Drug and alcohol addicts.
5. Paranoid personalities.
6. Aged persons.
7. Questions of epilepsy.

Now the law does not ask the doctor whether or not the patient is sick, neither does it ask for a diagnosis of mental disease, but asks the physician certain metaphysical questions one of the commonest of which is, "Does the prisoner know the difference between right and wrong?" Most experienced doctors take a pragmatic view toward this. As a practical matter, if a patient is grossly feeble-minded or if he has mental disease of a type ordinarily called insanity, most doctors answer all questions in the negative, that is, they say he does not know the difference between right and wrong, he does not know the nature and quality of his act, he is not able to exercise sufficient self-control, he would not have committed the act had he not had mental disease, and so on. On the other hand, if a sufficient degree of mental disease does not exist, wise doctors usually answer all the other questions positively. Obviously, when a puppy, before he has been trained, or in the process of training, has wet the floor he looks ashamed and shows every evidence of knowing that he has done wrong (or at least that he has done something punishable), while many a fanatic, otherwise not considered insane, has little or no recognition of the fact that his misdeed is wrong.

So my advice to the doctor is not to be ensnared by the metaphysical subtleties of legal opinion but to take a common-sense attitude.

Another difficulty comes by necessity in the law. It must be all or nothing. In the eyes of the law a person is either one hundred percent insane or one hundred percent healthy minded. He must either be punished or not, and no other course is open, though in the question of disposition, degrees of mental impairment may properly be considered. It is folly for the doctor to rebel against this necessity and insist that his patient is a little crazy because the law cannot entertain such a view.

The intellectual development of an individual is generally considered on a gradually increasing scale. The idiot rates intellectually at almost zero, and there is the normal adult level. Theoretically, there are all possible gradations between these points. Now according to all legal tests, if the intelligence is that of an infant or a wild beast, the person cannot be convicted. On the other hand, there is a zone ranging, we will say, on the intellectual scale between eight and twelve years where opinion very properly differs. Those who take a liberal point of view think that anybody who might be called feeble-minded ought to be excused for crime. Others feel that high grade feeble-minded persons after all as a practical social matter, should be held accountable for their acts.

The courts have not definitely settled this matter by a formula, so that we find in certain cases individuals with a fairly high I. Q. occasionally adjudged insane by courts. My own attitude has been formed somewhat from the circumstances of the individual case. Let us suppose that there is a mental age of ten years, but that the individual has always been childish in his behaviour, has perhaps been a bed wetter, has been dependent upon his father and mother for support, and has been particularly unstable emotionally. I can conceive of the propriety of saying that such an individual was insane. On the other hand, if he has been a person who has been about in society, who has had some schooling, who has worked steadily and who without extreme provocation gets involved in some malicious crime, one might properly say that he was to be held accountable. In other words, there are no exact criteria in these cases. One must conform to common practice in the community where he lives, but ordinarily only the lower grade feeble-minded are found to be not accountable.

Now as for the emotionally unstable. About one hundred years ago the concept of the moral imbecile was set up in England, that is, it was recognized that certain individuals who were not insane and not feeble-minded were lacking in moral perception, they had a moral blind spot so that they did not know the difference between right and wrong. This was a very helpful sociological hypothesis, but worked very disastrously in the court because such a defense could be set up for almost anybody. The moral imbecile has largely disappeared. His place was first

taken by the psychopathic personality, then came constitutional inferiority, next constitutional psychopathic state, then characterial deviate, and finally the general term of personality disorder includes him. Such persons are ordinarily not considered insane by the courts, though many of the great murder trials have come about by such a contention being set up as a defense. Many abnormal sex offenders come under this category. Their crimes are often startling and they are often obvious monsters who are dominated by morbid impulses. They are usually held to be accountable before the law. Although occasionally neurotics are committed as insane one rarely finds difficulty with them in criminal courts.

Ordinarily a person under the influence of alcohol or drugs is not considered irresponsible, the theory being that he has produced this condition through his own voluntary act and therefore cannot be held excusable. Oftentimes combinations of mental defect, personality disorder and drunkenness so obscure the real fact that a substantial defense is made. Cases of delirium tremens frequently cause confusion. The tendency of the law is to regard them as responsible, although, of course most physicians would consider a frank case of delirium tremens as utterly irresponsible.

There are certain morbidly contentious personalities in the community who always have a chip on their shoulder and who tend to quarrel with society. They are popularly considered as "nuts" and when such an individual gets into a broil and murder or some other serious crime results, the police and public are apt to consider that they are crazy. This often leads to great difficulty. My own judgment is that only those should be considered insane where the natural history of their disorder shows some definite form of mental disease. However quarrelsome a man may be, this of itself should not constitute insanity.

Nothing is more pathetic than to see an aged person brought before the courts, usually for a crime of a sexual nature. As age advances, with a waning or loss of sex ability, there is often a persistence of sex interest or desire. This often leads to attacks upon children or other helpless individuals. Oftentimes there is little intellectual decay, and yet my judgment has always been that where such an act represents a departure from a healthy state of the individual's mind and conduct, he should be held to have senile dementia.

A common claim before the courts is that the individual was suffering from an attack of epilepsy. This usually depends upon two things, in the first place a well established history of epilepsy, and secondly, evidence that the person was actually in an attack. This brings up the ever vexing question of amnesia. The so-called amnesia victim frequently comes before the court. Such a claim is usually considered fictitious by police and lawyers, and this is especially true of the alcoholic. Of course, if a man says he doesn't remember, the debate is at an end. There is no rule to go by. Epileptics ordinarily do have complete amnesia for their attacks. Hysterics and alcoholics rarely, though sometimes, have amnesia. It is to be assumed that if a person either through head injury, epilepsy or what not, actually was in an automatic state so that he did not remember, he is to be considered as incompetent.

Guardian and Conservatorship

Generally speaking a conservator has custody of the property of the individual, and the guardian has custody of the person and property. This comes up most often under two circumstances, either a defective or some type of an aged person. The latter is especially important. It is unfortunate that one of the most important acts of a person's life is often called for at a time when he is least able to perform it. In the midst of the old-fashioned home, old people may live with their children and gradually dement. Altruism and a high sense of honor indicate the attitude of all concerned and the person goes to his end, the property is distributed according to his known wish, and there is no litigation. But oftentimes such is not the case. Old people rarely live with their children at the present time. The families of their children may be entire strangers, and so there is a conflict of interest. Loving children hesitate to apply for a guardian or conservator fearing to offend the old people. Alas, only too often the barn is locked after

the horse is stolen. So many times I have been called in after an aged person has transferred all his property, married the cook or nurse, or made a will disastrous in its effect. One of the qualities of old age is emotional instability. The hand that feeds them, the voice that is nearest, often tends to be the one that is dearest. Out of sight, out of mind, is often the case. Too often the child who is nearest is perfectly conscientious in assisting the parent to transfer his property to him. The rights of the other heirs are considered merely technical. Physicians can often be of great assistance in helping the family over this difficult period, but somebody should be courageous and insist upon protection where it is obviously needed.

Testamentary Capacity

Testamentary capacity before the law is not synonomous with sanity. I have frequently been in court and heard the various decisions read defining testamentary capacity only to observe that any person in a state hospital might come within the scope of what is considered competent. Here again there is quite a bit of legal fiction. An out-moded psychology has formed the basis of frozen opinions. A person to have testamentary capacity must know the nature and extent of his property, he must know those who have a claim upon his bounty, and he must have sufficient mentality to put this knowledge into appropriate action. Alas, who can tell. Decisions are inevitably made upon inference drawn usually from very inadequate data. An old man in the eighties, dying of broncho pneumonia, asks the nurse to get his bank books from his trunk. She procures them. In a burst of gratitude for what she has been able to do for him, and with some help he signs his name transferring the books to her. She is grateful and tucks them away. The next day the old man is dead. His children after an appropriate time search his effects. They thought he had some money, but it appears that he had not. At last they discover that the nurse has the money, several thousand dollars. They are obliged to pay his bills. There is nothing for them. Did the old man know what he was doing? Was he competent? He had never been considered insane before. There is ample testimony of his mental vigor just a few weeks earlier. No one saw him the day of the act except the nurse. The doctor came in for a minute, said good morning, and states that he seemed to know what he was about. Yet was he capable of evaluating the rights of his children and the comparative meagerness of the contribution of the nurse of a week to his total happiness. Reason cries out emphatically no. The law often technically says yes. What shall we do about this? Here again there is no higher function of the medical profession than to furnish skilled, accurate, complete and honest evidence in such a case. The doctor should never assume the role of lawyer. Nothing is more disgusting than to see a doctor snooping around trying to regulate the affairs of his patients in all their details, and yet to stand by uninformed, like a jellyfish, and see an old man who, in fact loves his children, leave his heirs destitute because of a momentary impulse, because the doctor did not inform himself as to the mental condition of his patient, is tragic. The doctor's glance or casual opinion is often no better than a street car conductor's. Generally speaking, the doctor's opinion is better than that of other persons because he has more facts. So let me say it seems to me that every physician having to do with an aged person, whether a guardianship or a will is concerned, is duty bound to keep his eyes and ears open. So many times the doctor, while attending an old person, is called in a hushed voice into another room and there a paper is put before him purporting to be the last will and testament of the individual, and he is asked to sign as a witness while the old man makes a scrawl. The doctor has pictures of the old man in the prime of his life. He recognizes the doctor when he enters the room, what he says is all right, and to the point. But there should be a more extended exploration of the person's mental capacity and an evaluation of the various stresses that are playing upon him and of his emotional reaction and the good faith of those who are participating, whether lawyers or beneficiaries. Then and then only can the doctor give a worthy opinion.

Contracts

Mental disease is often associated with advanced arterio-sclerosis but the existence of arterio-sclerosis is not evidence of mental disease, and neither are other evidences of physical illness. The doctor must judge after adequate investigation of the working of the mind of his patient, if he is to be of assistance. This is often particularly difficult in cases of aphasia. Similar causes apply to the ability to make a contract, especially the marriage contract. Courts, in general, are pretty liberal in the matter of marriage. I have seen a marriage declared valid by the courts when four days after it had taken place the woman did not remember the name of her husband. Old people are very susceptible to flattery and to attention from young persons of the opposite sex, and it is much better to have a guardian appointed prior to an improper marriage than to attempt to have the marriage annulled afterwards.

Suicide

There is a general assumption that a person must be insane if he commits suicide. This is not warranted. In a study I made a number of years ago, it appeared that about one-third of the suicides in Massachusetts were frankly insane. Another third had some evidence of psychopathy, while the final third represented persons, otherwise healthy-minded, who had been subjected to terrific stresses from overwhelming situations. Suicide as a cause of death results in one of the largest claims against insurance companies. These companies try to protect themselves by having a clause in their policies excluding suicides, yet they make very little investigation, tending to exclude potential suicides. As a matter of fact, this is a very difficult matter to guard against. Insurance companies, advised by lawyers and surgeons, regard the problem as one consisting largely of individuals who have determined to kill themselves, and who then seek insurance policies. This is rarely the case. What happens is that some person who has carried a large policy for many years either through advanced age or illness becomes somewhat enfeebled and des titute. He finally becomes haunted by the idea of the insurance policy. It would be much more reasonable for insurers to keep track of their large policy holders in their later years, rather than try and anticipate suicide claims by excluding those who intend to kill themselves.

Tort

I shall discuss but two of the neuro-psychiatric conditions which frequently result in actions of tort, namely head injuries and neurosis. Head injuries have become of increasing importance due largely to the advent of the automobile with its high rate of speed and frequent accidents. In court, attention is often focused upon the question of whether or not the skull has been fractured. Actually this is of little importance. A much more fundamental question is the degree to which the brain has been injured and the extent to which recovery has taken place. Of course, common-sense would indicate that there is more likelihood of serious brain damage in an extensive injury with prolonged unconsciousness, but this is not always the case. Frequently serious injuries with prolonged unconsciousness and many neurological signs are followed by complete recovery. Likewise, supposedly minor injuries are often followed by prolonged illness and disability. Cases with fractured skull, unconsciousness, neurological signs, and bloody spinal fluid may clear up promptly and the individual return to work in a few weeks or months and have no further trouble. Such cases are entitled to compensation on the same basis as in the case of any other injury, that is, the amount of suffering involved and the amount of time lost from work. They are not entitled to compensation for possible or conjectural future mental trouble.

There is another type of case with similar symptoms which does not recover. There may be a residual dementia with intellectual loss, disability, paralysis, epileptic attacks, and what has latterly been called the traumatic constitution. The first three are usually fairly obvious, though claims of unconscious attacks should be scrutinized with great care lest the patient be deprived of his just deserts where actual epilepsy has occurred, or the insurer or other defendant been penalized on account of supposed epilepsy which is in fact

a pure emotional disorder. Functional nervous disease, that is, subjective complaints without demonstrable pathology, may occur following head injury as well as in any other case. Aside from this there are certain individuals who have obvious brain damage and who make a superficial recovery but have a persistent enfeeblement of their mental processes resulting in marked disability. It is almost impossible to differentiate this condition from a neurosis. The persistence of symptoms without marked emotional disturbance point toward an organic basis for such complaints.

Many lawyers smile when the words "traumatic neurosis" are uttered in court or by a physician. This does not seem to me a good term because it not only makes a medical but a legal diagnosis. It is perfectly proper for a doctor to make a diagnosis of neurosis and to say that in his opinion the alleged accident was an adequate cause, but it is a function of the court to determine whether or not it is in fact a traumatic neurosis. This is often the purpose of the trial. Unfortunately there are no criteria which enable a physician to say with one hundred percent assurance that a person is suffering from a neurosis due to an accident. The complaints usually have an emotional background making for exaggeration and dramatization. The signs and symptoms present are largely subjective so that in the last analysis we are dependent upon a thorough knowledge of the situation and upon good faith on the part of the patient and the attorney. I think it is better to proceed in the examination of such cases as if there had been no accident. A careful inquiry should be made as to the background of the patient. There should also be an appraisal of his personality and nervous stability, and perhaps most important of all, an inquiry as to his situation at the time of the accident. There is usually, in my opinion, some evidence of constitutional nervous instability and there is evidence, frequently, of other causes of emotional unrest preceding the accident. A woman of thirty-five, whose husband died a number of years ago leaving her with a large family to support, worked assiduously in a mill trying to keep the brood together. There had been continual economic stress and much sickness among the children, yet she carried on at her work until the day of the accident without medical attention herself. She then slipped on a grease spot on the floor and had comparatively little physical injury. From then on she continuously complained of insomnia, headaches, coccygeal pain, shortness of breath, lassitude and many other symptoms commonly found in the neuroses. In other words, we have the stage all set for an emotional collapse awaiting any one of many stimuli which may precipitate a more or less chronic nervous disorder. In such a case, I have no doubt as to the genuineness of the disorder and have no hesitancy in asserting this belief in the courts. On the other hand, we frequently see unstable individuals, perhaps irregularly employed, who have had no such preparation for a neurosis, and who have an accident, perhaps not very clearly defined and who later complain of a lame or weak arm or back without the general symptoms of a neurosis. In these cases it seems more likely that the patient is trying to exploit a minor injury for purposes of gain. Such cases require great wisdom, absolute honesty and cautiousness on the part of the physician.

Accident as a cause of insanity is relatively infrequent. Where it is evident that there was a gross brain injury and acute mental symptoms develop in the course of convalescence, there would seem to be little doubt as to the relation.

There are those who believe that injuries may precipitate paresis or tabes in a person with syphilis. I am, personally, very doubtful about such cases. Again, where relatively minor injuries occur and mental symptoms come on some little time after such accidents I think it unreasonable to attach a causal relationship. There are certain aged persons with evidence of vascular disease who do not come back following severe injury, even though physical recovery may seem to be complete.

I am very happy to have had the opportunity to meet the members of the Kennebec County Medical Association. I have enjoyed reviewing with you a few of the situations in which it becomes necessary for medicine and law to coöperate.

*Sulfapyridine Therapy in Pneumonia**

By Louis A. Parrella, M. D., and E. E. Brown, M. D., Lewiston, Maine

The recent clinical successes of sulphanilamide in the treatment of streptococcal, meningococcal and gonococcal infections has furnished a new stimulus for the study of chemotherapeutic agents in the treatment of disease. From these numerous studies sulfapyridine has emerged as a valuable drug because of its effectiveness against pneumococci.

Whitby in 1938 using this sulfapyridine was among the first to notice the protection against pneumococci afforded by this drug in mice. These results were confirmed both in vivo and in vitro by A. Fleming who also found that the action of the drug was bacteriostatic rather than bacteriocidal in action. Therefore the actual killing of the bacteria had to be done by the natural defenses of the body and he proved, too, that this action could be greatly enhanced by the use of type specific serum. Recent clinical surveys do not appear to have made much use of this fact. Perhaps the investigators want to try the effect of the drug alone in pneumonias. We have used both drug and type specific serum in two of our cases which will be included in this paper.

After reviewing some of the current literature it can be safely stated that the dosage of this drug in the treatment of lobar pneumonia is fairly well stabilized. Most men have found from clinical experience and case studies that one hundred and twenty grains in divided doses during the first twenty-four hours have produced desired clinical results with blood levels ranging from five to ten milligrams per cent. and that these levels could be maintained by giving ninety grains daily until the temperature had remained normal for forty-eight hours. The dosage could then be cut to sixty grains a day for several days and then the drug could be discontinued. Higher blood levels have failed to produce better results. Sulfapyridine is very insoluble and is not absorbed evenly so that stipulated amounts will not produce the same blood level in all patients. For this reason the dose may have to be varied with the patient. Higher doses are advised when the temperature does not come down fairly rapidly. It has been the practice of some men, notably Meakins and Hanson of Montreal, to give ten grains of sodium bicarbonate not only to bring about more regular and more rapid absorption, but also to relieve some of the nausea and vomiting which the drug may produce. It might be mentioned that MacLean, Rogers and Fleming of St. Marie's Hospital in London have experimentally proven that pneumococci can establish a tolerance or fastness to the drug in infected animals. They therefore recommended strongly that the initial doses of the drug be large.

In most of the cases treated at our hospital the dosage generally employed was slightly less than that advocated above; namely, ninety grains the first twenty-four hours, sixty grains the next twenty-four to forty-eight hours, and then forty grains daily until the temperature was normal for four or five days.

The most serious difficulty encountered in the use of sulfapyridine in our series and in those recently reported was the frequency with which it produced anorexia, nausea and vomiting. Almost all of the patients had this complaint at one time or another during the course of its administration. Graham et al. of Toronto have found that most patients tolerate the drug better if the tablets are crushed and given in the form of a powder in water, milk or fruit juices accompanied by a small dose of sodium bicarbonate. We tried this in two of our cases without success. In pronounced nausea and vomiting Graham states that these symptoms may be controlled by such sedatives as paraldehyde or chloral hydrate and bromides given by rectum. On several occasions he found it necessary to pass a duodenal tube not only to give the drug but also to maintain the nutrition of the patient. Other men have administered the drug rectally suspended in water or intramuscularly suspended in oil where nausea

* Read by Dr. Brown at the staff meeting of the Central Maine General Hospital, May 1, 1939.

and vomiting were severe. However, it was impossible to attain a blood level of over two milligrams, although the doses were exceedingly high. The use of the soluble salt of sulfapyridine (the sodium salt) intravenously has been suggested in order to avoid the nausea and vomiting usually produced. A recent work showed that these distressing symptoms occur about as frequently even when the drug is given intravenously in the form of the soluble sodium salt.

Other toxic manifestations reported in the literature were not seen in our small series of cases. Moderate methemoglobinemia has been reported in several cases although it has rarely been severe enough to cause any marked color changes in the mucous membranes or the finger tips. Severe cases of methemoglobinemia were treated by giving methylene blue intravenously. Since there was no significant improvement of the patient clinically, it was decided that the methemoglobinemia due to the drug was not the cause of a serious disturbance to the patient and that the methylene blue treatment was unnecessary. In a control group of pneumonia patients it was shown that the incidence of cyanosis was as high in the patients not receiving sulfapyridine as in those receiving the drug.

The consensus of opinion seems to be that there is a moderate fall in hemoglobin and red cell counts but that this did not exceed the expected fall in any infectious disease. A small proportion showed a slight but definite depression of the total white count with polymorphonuclear leucopenia. Granulocytopenia developed in one patient who had received seventy-nine grams of the drug in nineteen days. His total white blood count was 900 with eight per cent. polymorphonuclear cells in the diffential count. When the drug was interrupted this patient made a good recovery. It will be noted that seventy-nine grams is about three times the total amount given to the average serious case of pneumonia. Where prolonged treatment is contemplated or large doses of sulfapyridine are to be given, the white blood count should be watched closely.

In a series of one hundred and eight cases reported from the City Hospital of London six patients developed rashes in from three to fourteen days after treatment was started. Two patients of a series of thirty in Toronto developed rashes. These eruptions were either of a morbilliform or scarlatinal type. With discontinuance of the sulfapyridine therapy the rashes quickly disappeared. No mention of jaundice as a toxic manifestation is made in the literature.

Graham of Toronto recently reported four patients who showed gross hematuria which was usually accompanied by ureteral pain. No casts were present in the urine and the blood disappeared completely in a few days without evidence of residual damage to the kidney. The cause of this hematuria has not been determined, but the presence of large numbers of jagged crystals of the drug in the freshly voided urine suggests this as a possible cause.

The only toxic effect on the nervous system noted in several large series of cases was transient mild mental confusion in a few of the patients.

In quite a few of the cases reported and in our few cases a secondary pyrexia occurring between the third and tenth day was observed. This was accompanied by a rise in the total white blood count. Too early withdrawal of the drug or an extension of the pneumonic process has been offered as an explanation for this phenomenon. Secondary pyrexia due to drug fever has also been observed in a few cases. Drug fever may be distinguished from the first type of pyrexia mentioned by the absence of a leukocytic response and the failure of the fever to subside following increased doses of sulfapyridine.

In comparing the treatment of pneumonia with sulfapyridine and serum, one notes certain obvious advantages of therapy with M. & B. 693. The necessity of typing sputum is eliminated. Although it might be of academic interest to know whether it is a pneumococcal pneumonia that one is dealing with, response to the use of this drug would give one an indication of the infecting organism. (It may be stated here parenthetically that if typing is to be done, it should be done before treatment with sulfapyridine is started because the organisms are affected by the drug. Subsequent typing becomes difficult as the

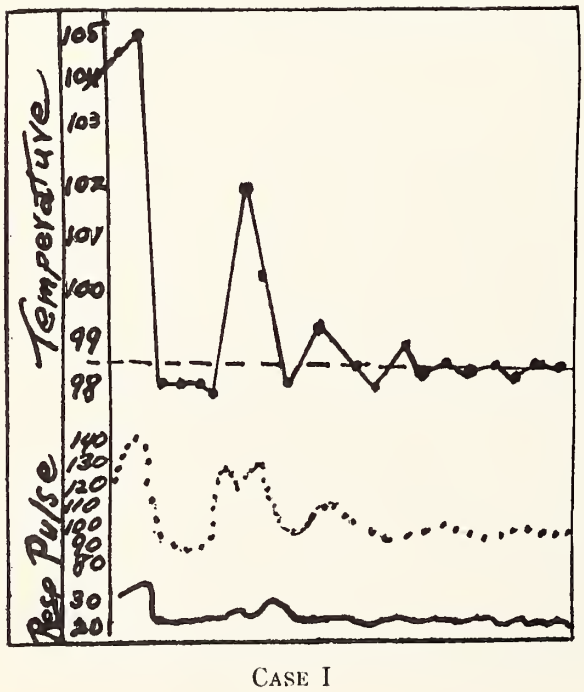
membrane surrounding the pneumococcus is disturbed so that bizarre quellung reactions are noted. We had this experience with one of our cases.) Serum therapy must be started at least within seventy-two hours of the onset, whereas with drug therapy the duration of the disease when treatment is begun is not of much importance. Serum-sensitive patients are no longer a problem because sulfapyridine may be used instead. The simplicity of this drug treatment is a great advantage. Immunotherapy requires frequent intravenous administrations of the serum and consequently the physician must be in almost constant attendance over a period of twelve hours or more while the treatment is carried out. This drug, however, is given orally and does not require such close supervision. With serum therapy a patient may be made serum sensitive so that any future immunotherapy may present serious dangers and problems. Among the disadvantages one might list the toxic effects of the drug, among which nausea and vomiting are the most common and distressing. This may not necessarily preclude the administration of the drug. Experimentally it has been shown that some strains of pneumococci are insensitive to the drug so that conceivably in some types of pneumonia sulfapyridine may be ineffective.

The following are brief case summaries of six patients on our Medical Service who were treated with sulfapyridine:

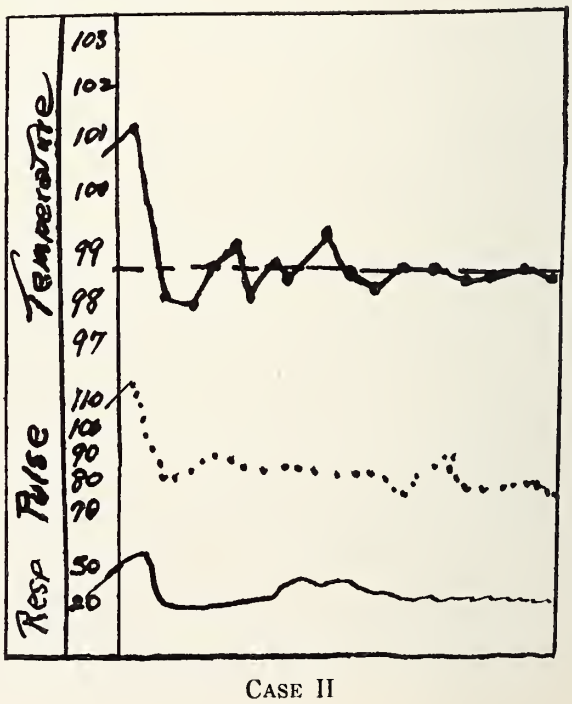
Case I

This was a twenty-six-year-old married female with type VIII lobar pneumonia (left lower lobe) who was severely ill on admission. Her white blood count at that time was 21,500 with 92% polys. Treatment with M. & B. 693 was begun immediately on what was the fourth day of her illness. As her temperature fell within twenty-four hours, the dose of sulfapyridine was reduced. On her third hospital day the temperature was normal and her white blood count was 8,800 with 66% polys. The next day the patient developed a secondary pyrexia with a rise in white count to 26,500 with 91% polys. Considering this a flare-up or an extension of the pneumonic process we increased the dose of sulfapyridine and then gradually decreased it and finally discontinued it on the tenth hospital day. During the administration of the drug nausea and vomiting were observed. Supportive treatment, including two small transfusions, was given. The total dosage of sulfapyridine was twenty-seven grams. She made a good convalescence and was discharged on her nineteenth hospital day.

In this case a fairly typical response to the drug is exemplified. Following a secondary pyrexia which was controlled by increased dosage she made a good recovery though she was very sick on admission. The transfusions were given to speed up her convalescence and because she had developed a moderate secondary anemia.



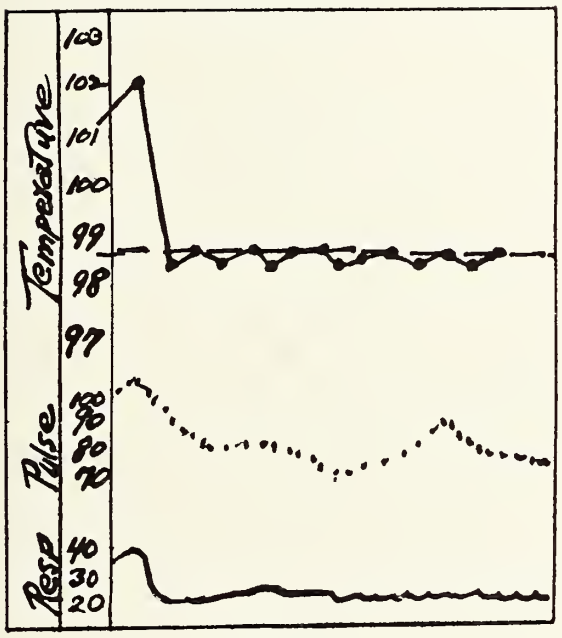
Case I



Case II

Case II

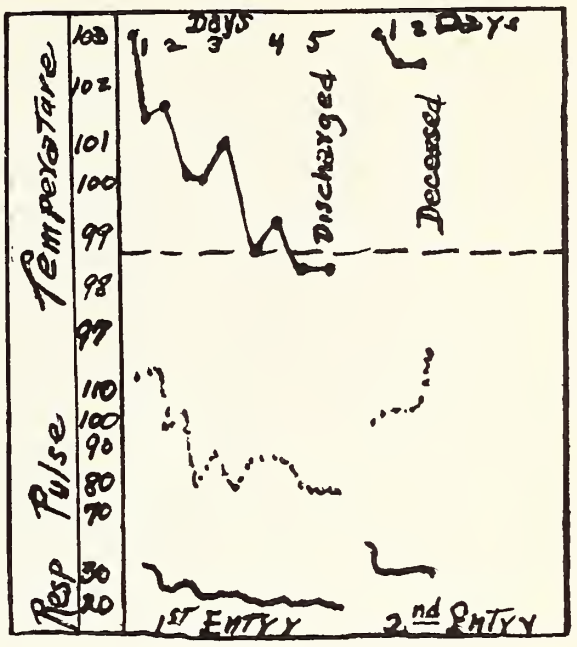
The patient was a forty-seven-year-old married female who was moderately ill on admission. The sputum was not typeable and the blood culture was negative. A lobar pneumonia of the right lower lobe was found. Sulfapyridine therapy was instituted immediately on what was the tenth day of her illness and the total dose given over a period of ten days was twenty-six grams. Her temperature became normal within twelve hours and remained essentially so throughout her hospital stay. The only toxic manifestation was nausea and vomiting which were not distressing. She was discharged on her eighteenth hospital day improved.



Case III

Case III

This was a thirty-one-year-old married female who entered the hospital on the third day of her illness with a lobar pneumonia of the left lower lobe. She was moderately ill on admission and responded immediately to sulfapyridine. A dose of twenty-two grams was given over a period of eight days. Here again there was mild nausea and vomiting. She made an uneventful recovery and was discharged on her sixteenth hospital day. The blood culture in this case was negative and the sputum was not typeable.



Case IV

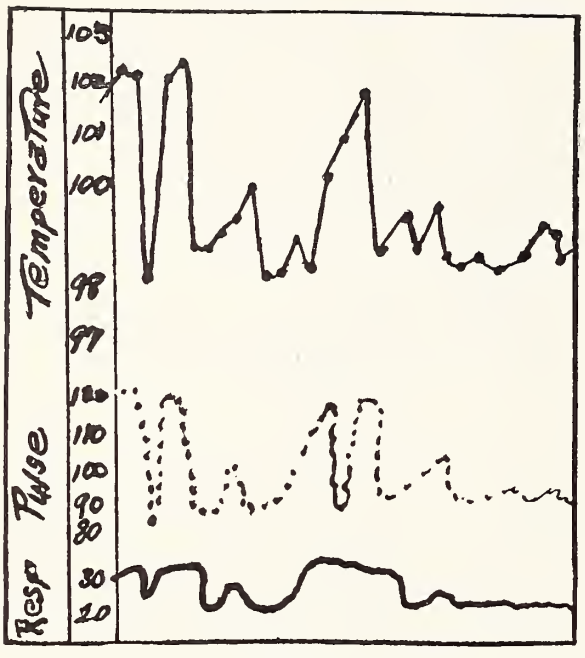
Case IV

A thirty-nine-year-old female who was moderately ill entered the hospital on the fourth day of her illness. Physical examination showed evidence of rheumatic heart disease and a bronchopneumonia which was confirmed by x-ray. The sputum was negative for typing. Her temperature gradually came down and was normal on the fifth hospital day after a total dose of thirteen and a half grams of the drug had been given. On the insistence of the patient she was discharged on the sixth hospital day to continue her convalescence at home.

Six days later she re-entered the hospital because twenty-four hours before she had developed chills, fever and productive cough. This time she showed consolidation of the right and left sides of the chest. She was given only one dose of sulfapyridine, following which the drug had to be discontinued because within four hours of admission she developed extensive pulmonary edema and became moribund. In spite of intensive supportive treatment she expired twelve hours later. The sputum was not typeable. The white blood count at the time of her second admission was 22,900 with 81% polys and on the day of her death it was 48,000 with 91% polys.

An autopsy revealed large heavy lungs, of which the right one weighed 960 grams and the left, 850 grams. On section all lobes were consolidated and presented a dark red, firm,

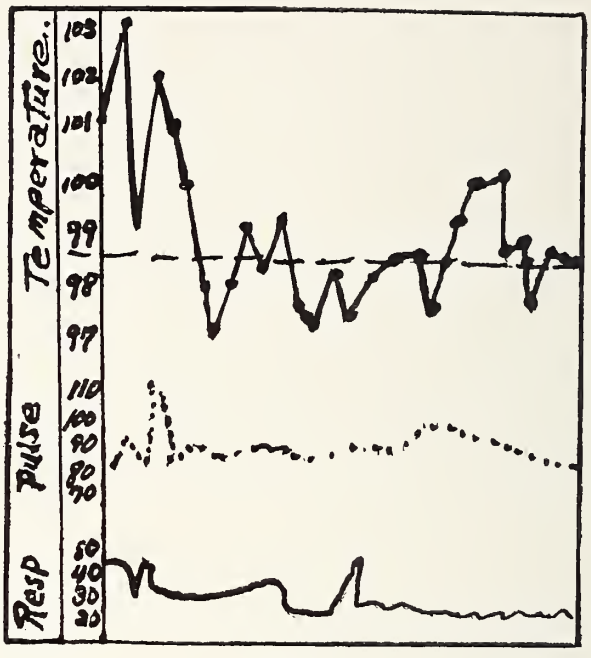
rubbery surface from which a considerable amount of frothy fluid could be expressed. The bronchioles when sectioned showed a deposit of frothy pinkish fluid with the mucosa markedly injected. A marked mitral stenosis and definite rheumatic lesions were also demonstrated in the heart.



Case V

Case V

This was a forty-five-year-old married female who was desperately ill when admitted to the hospital. Type I pneumococcus was found in her sputum and the blood culture was negative. Because of her serious condition we decided to use both the drug and serum in this case. 120,000 units of type specific serum was given over a period of twelve hours and sulfapyridine therapy was instituted on the third day of her disease. The temperature became normal within twelve hours but twenty-four hours later it had risen to 102 degrees. We attempted to give her more serum but could only give her 20,000 units because she developed a mild reaction after receiving that amount. The dosage of sulfapyridine was increased, following which the temperature became normal on the fourth hospital day and remained so until the eighth and ninth day, when she developed a transient secondary pyrexia. On the sixteenth hospital day the patient developed a phlebitis of the right saphenous vein from which she had almost recovered a week later. At this writing there are no signs of pneumonia present and since the patient has made a satisfactory convalescence she will be discharged shortly. A total dosage of thirty-two grams of sulfapyridine was given over a period of fourteen days.



Case VI

Case VI

The last patient in this series is a sixty-year-old married female who was desperately ill on admission to the hospital. She had had pneumonia on five previous occasions and her last attack had occurred five years ago. For the past two years she had been on a special regime because of hypertension. Her blood culture was negative and her sputum showed type I pneumococcus. 200,000 units of type specific serum were given over a period of twenty-four hours and sulfapyridine therapy was instituted on the third day of her illness. About ten hours after entry the patient showed increasing dyspnea and signs of pulmonary edema. She was digitalized rapidly, given oxygen intranasally and other supportive measures. Responding well to this treatment her temperature became normal on the fourth hospital day and after varying a few degrees for several days it remained normal until a week later when a transient secondary pyrexia was noted. This reacted well to increased dosage of sulfapyridine. Four days later the patient complained of pain in her ankles, knees and wrists which was not accompanied by a rise in temperature or physical signs. Although no mention of joint pain as a toxic manifestation of sulfapyridine could be found in the litera-

ture, the joint pains in this case disappeared when the drug was discontinued. The remainder of the patient's convalescence was uneventful and she was discharged on her twenty-fifth hospital day. The total dose was thirty-five and one-half grams.

General toxicity from her infection and a delayed serum reaction were also thought of as possible etiological factors for her joint pains. A combination therapy was used in the last two cases because the patients were seriously ill when admitted to the hospital.

In conclusion there are certain points that may be emphasized. Though this drug quickly produces an afebrile state and shortens the course of the disease slightly, the course of the pathological process is relatively unaffected. A secondary pyrexia three to ten days later appears to be a very common experience and responds to further therapy. As for toxic manifestations, nausea and vomiting are very frequently present though others, such as drug fever, hematuria, cyanosis, agranulocytic leukopenia, various skin eruptions and mental confusion, may be occasionally encountered. It would seem that there is a place for a combination of both chemo- and immunotherapy, especially in the serious cases. The work of Fleming has showed sound scientific basis for this combination therapy.

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1. The early symptoms of cancer of the throat are mostly trivial:—

(a) abnormal sensations in the throat, characteristically persistent and well localised;

(b) changes in the voice;

(c) enlarged cervical glands.

2. Persistent dysphagia is a late symptom except in post-cricoid cancer.

3. Examination with the laryngeal mirror is essential in cases presenting such symptoms and is the only readily available method of detecting an early cancer.—Robin Pilcher, M. S. Taken from *Medical World*, London, April 8, 1939.

When irradiation for corpus carcinoma is reserved for the patients who are considered very poor surgical risks, the results obtained from this therapy cannot be very brilliant. However, something has been accomplished in this group of patients in the form of an arrest of the disease in some and of palliation in others. In all, it has controlled the bleeding, it has stopped the foul vaginal discharge, of which they complained, and it has given them comfort by lessening their pain. This part of the treatment has been worthwhile. —Louis E. Phaneuf, M. D., *The Am. Jour. of Roentgenology and Radium Therapy*, June, 1938.

The Pneumococcus and Sulfanilamide

REPORT OF TWO CASES

By Harold I. Goldman, M. D., Freeport, Me.

In the past one and one-half years the literature has been deluged with reports on the chemical action, theory, and results obtained with sulphanilamide. There have been numerous reports on the results obtained in pneumococcus infections, both by the drug alone and also in conjunction with serum therapy.

Millet (1) reported one case of Type III in which good results were obtained with the drug given orally; Mertins (2) a case of pneumococcus meningitis following a middle ear infection and operation and recovery; Heinzelman, Hadley, and Mellon (3) in Type III nine cases treated with Prontylin had a 22% mortality, while in ten cases where the drug was not used the mortality was 80%; Caldwell and Byrnes (4) report a recovered case of pneumococcic meningitis where the drug was given orally and intramuscularly; Millet (5) a case of pneumococcic meningitis where the drug was given intrathecally. In this instance the patient died and subsequent necropsy showed no demonstrable injury to the brain substance. Recently Price and Myers (6) report a series of 115 cases of pneumococcic pneumonia treated with sulphanilamide in uniform doses, 40 controls with Felton serum, 94 controls with no specific therapy. They had a mortality rate of 15.7% for the sulphanilamide group, 30.8% for the entire control group. In Types I, II, V, VII, VIII, the mortality rate was 10.5% for the sulphanilamide group and 27.5% for the serum group. Hewell and Mitchell (7) report six cases of pneumococcic meningitis treated with sulphanilamide with three recovering completely.

Following are two case reports in which I was able to get the patients hospitalized and sufficient laboratory work done.

Case I:

L. W. Age, 5 yrs. Weight, 60 lbs.

Chief Complaint: General malaise.

Present Illness: The patient complained of waking up in the morning with a chilly feeling and refused his breakfast. His mother sent him to school. At noon he refused his luncheon and complained of general malaise. He was put to bed, and when his temperature appeared to rise alarmingly a doctor was called.

Past History: Essentially negative. Normal birth. Orange juice and cod-liver oil at the prescribed time.

Physical Examination: Showed a very well-developed and well-nourished young white male child, flushed, slightly cyanotic, and appearing toxic. Temp. 104.0 F. by mouth, pulse 150, resp. 32/min. Head, eyes, ears, nose, throat, and abdomen were essentially negative. The rate at the apex was very rapid, but there were no cardiac abnormalities. The lungs showed moderate dullness and increased bronchial breathing over the middle lobe of the right lung, also a few scattered crackling rales.

Neurological: Showed positive opisthotonos, positive bilateral Kernig and Babinski, and a questionable positive Gordon. Ophthalmoscopic examination revealed no abnormalities.

A clinical diagnosis of lobar pneumonia with complicating pneumococcic meningitis was made and the patient brought to the State Street Hospital in Portland.

Course in Hospital: On admission an immediate lumbar puncture was done. The fluid was under moderately increased pressure and grossly clear. Cell count was W. B. C. 8, R. B. C. 87. The centrifugal sediment stained showed the Diplococcus Pneumoniae. The globulin was slightly positive (Pandy). Culture of the fluid showed pneumonia Type IV. W. B. C. on admission was 10,700. The urine was essentially negative. No blood culture was done.

Prontylin by mouth was started. Gr. 50 was given in the first eight hours; gr. 110 in the next seventy-two hours. After eight hours

the temperature dropped to 98.4 F., pulse 94, resp. 22/min. The temperature never rose again beyond 101 F. After an uneventful convalescence the patient was discharged in fourteen days. W. B. C. dropped to 6,500, but rose to 10,500 after the Prontylin was discontinued. There was moderate cyanosis present during the administration of the drug.

We feel that a large factor in the recovery of this case was due to instituting therapy very early in the disease.

Case II:

A. C. Age, 11 mos. Weight, 16 lbs.

Chief Complaint: Difficulty in breathing, temperature, and cough for three days.

Present Illness: Patient had whooping cough a few months previous, which left a slight cough. Three days ago he vomited and his mother thought he also showed signs of a slight cold. When it apparently grew much worse she brought him to the office.

Past History: Normal birth, bottle fed, had orange juice and cod-liver oil at the prescribed time, and dentition normal.

Family History: Negative.

Physical Examination: Showed a well-developed and well-nourished white male infant, markedly cyanotic, and apparently moribund. Temp. 104.0 F. rectal, pulse approximately 170, resp. 72/min. and very shallow. Head: Posterior fontanelle closed. Anterior fontanelle still open, soft, with no gross evidences of increased intracranial pressure. Eyes, ears, nose, throat, negative. Heart: Rate too rapid to detect any abnormal sounds. Lungs: Marked dullness and bronchial breathing over the lower lobes of both lungs with coarse, crackling rales. Abdomen: Negative.

Neurological: Questionable positive Babinski. No other abnormal signs. A clinical diagnosis of bilateral lobar pneumonia, probably a fulminating infection, was made and the patient brought into the State Street Hospital at Portland.

Course at Hospital: On admission the temperature was 103.0 F. rectal, pulse too fast to count, resp. 72/min. The W. B. C. was 15,100, the urine essentially negative. Direct smear from the posterior naso-pharynx showed on stained smear and culture a pneumococcus which did not conform to any of the known types on agglutination.

Prontysil in 5 cc. doses was administered every two hours intramuscularly until 75 cc. were given. This was accompanied by a hypodermoclysis of 100 cc. of normal saline every six hours. Eight hours after admission the temperature was 105.0 F. rectal, pulse too fast to count, resp. 64/min. Twenty-four hours later (32 hours after Prontosil was started) temperature 99.6 F. rectal, pulse 155, resp. 40/min.

45 cc. of Prontosil in 5 cc. doses was given intramuscularly in the next 48 hours. The temperature varied from normal to 102 F., but the peaks were lower each day. The patient was markedly cyanotic and the urine a very dark red as long as the drug was being given. The W. B. C. remained essentially unaffected.

After an uneventful convalescence the baby was discharged home in ten days.

Conclusions

Sulfanilamide is a valuable aid in the therapy of pneumococcus infections, but only if used in sufficient dosage. In these two cases, in my opinion, it undoubtedly averted a fatal outcome.

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The President's Page

To the Members of the Maine Medical Association:

The 87th Annual Convention at Poland Spring was the largest and perhaps the best Convention we have ever held, and much credit is due to those who made the arrangements.

The meetings of the House of Delegates were well attended, although several delegates were absent, and the routine business was attended to promptly.

There was some discussion on the resolution disapproving the Wagner Health Act, but the final vote was almost unanimous.

The Conferences were generally interesting and well attended.

The Scientific session Monday afternoon in charge of Dr. Gottlieb and Dr. Reginald Fitz was remarkably well planned and carried out. The idea deserves to be repeated.

The Tuesday afternoon session was also excellent, with fine addresses by President Bunker, Professor Blake of New Haven, Professor Moorhead of New York and Dr. Morrison of New York.

The election of Thomas A. Foster of Portland as President-elect was unanimous, and both Dr. Foster and the Association are to be congratulated.

Several hundred members and guests attended the final banquet Tuesday evening.

Dr. Morris Fishbein, Editor of the Journal of the American Medical Association, was the principal speaker, and his address was both instructive and highly entertaining.

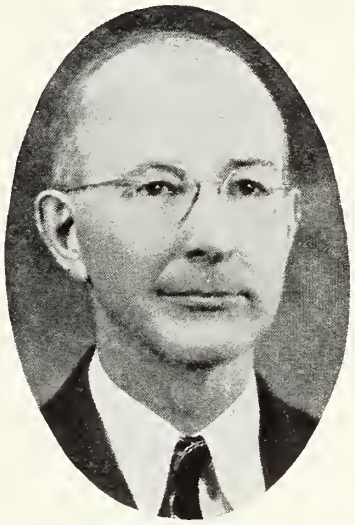
Fifty-year medals were presented to

Charles B. Sylvester, Portland,
Gustav A. Pudor, Portland,
Bernard A. Bailey, Wiscasset,
Henry J. Durgin, South Eliot,
Gilbert M. Elliott, Brunswick.

It is well worth while for every doctor in the State, who can possibly do so, to attend these annual meetings of our Association.

George L. Pratt.
President, Maine Medical Association.

COUNCIL MAINE MEDICAL ASSOCIATION, 1939-40



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Chairman

Wm. A. Ellingwood

R. V. N. Bliss

G. H. Stevens

Stephen A. Cobb

E. M. McCarty

Editorial

The Eighty-seventh Annual Meeting

The eighty-seventh annual meeting can and will go down on record as one of the most successful in the history of the Maine Medical Association. The total registration was 466, many of the members were accompanied by their wives and it was the universal expression that the scientific and entertainment program was one of the best ever presented to the members. Guest speakers from important clinics brought the concensus of medical teaching on subjects of daily occurrence and importance which were also amplified by the addresses and papers of our members. That panel discussions are appreciated by the members was made manifest by the attendance and universal discussions by members and guests. Some of the chairmen followed a course to be commended; they called personally for opinions on the points brought out in the presentation of the panel with the result that interest did not lag and many additional valuable points were developed. It is with pleasure that the most excellent facilities, service and coöperation of the management of the Poland Spring House are acknowledged and which received deserved recognition from our president. It is no small task to conduct such a service efficiently and smoothly.

The commercial and educational exhibits were of exceptional value and quality. That their variety and importance were appreciated is without question since the attendance and interest shown must have been gratifying to those holding them. These, together with several motion pictures, made no small contribution to medical education.

Comments on our guest speaker, Dr. Morris Fishbein, seem superfluous. After a most entertaining preamble he gave a most lucid talk on the proposals and activities of the Federal Government in regard to organized medicine as the story has been unfolded to date. The House of Delegates spoke in no uncertain terms their opinion in regard to the Wagner Bill in the form now before the Senate. Copies of this resolution were released to the press of Maine and sent to our Senators and Representatives in Washington. If one thing, however, is important and necessary it is that each member of the Maine Medical Association regard it as his duty to explain to his patients and friends the dangers and fallacies inherent in this bill and to write personal letters of objection to our Senators and Congressmen. It was with pleasure that we also had as a most welcome guest the President of the Maine Pharmaceutical Association: Burton Murdock of Kennebunk. His message impressed all with his sincerity of purpose and his appreciation of the task confronting the profession so closely allied with medicine.

What organized medicine faces today in way of changes and developments in relationships and administration of practice no one can predicate. That we have in the past served our State and our communities with one common interest—the health and welfare of the people—warrants the confidence that the important and vexing problems now before us will be met and considered calmly but with a progressiveness that is commensurate with the time and need. To protect and guarantee the future of medicine, to provide the education for and assure the quality of physicians who yearly must assume the places brought by death and retirement is no small task. It is, however, our task for the hour that politicians and bureaucrats control in any way the education of the physicians of the future medicine as we know medicine will cease to exist.

In these unsettled days, not only for medicine but every other profession and business, your officers, committee chairmen and members deserve and undoubtedly will have that hearty coöperation that insures for harmony and success. Medicine and the allied professions of pharmacy and dentistry today, as never before, are faced with problems and civic responsibilities of the utmost gravity. As educated men and women we must bring our influence and experience to bear on them.

Program
Maine Hospital Association
Lakewood, August 30, 1939

Morning Session
10.00 A. M.

Invocation
Rev. Ludger Ouellette, Pastor Notre Dame Church, Skowhegan

Report of National Hospital Day Committee
Helen Goodwin, R. N., Supt., Rumford Community Hospital, Rumford

Report of Executive Committee
Pearl R. Fisher, R. N., Supt., Thayer Hospital, Waterville

Report of Delegate to American Hospital Association
Stephen S. Brown, M. D., Medical Director, Maine General Hospital, Portland

Report of Legislative Committee
Mr. Samuel Stewart, President, Board of Directors, Central Maine General Hospital, Lewiston

Extension Services — Bingham Associates
Julius Gottlieb, M. D., F. A. C. P., Pathologist, Central Maine General Hospital, Lewiston
Discussion by:
Samuel H. Proger, M. D., Medical Director Joseph H. Pratt Diagnostic Hospital, Boston, and member of Bingham Associates
Joseph H. Pratt, M. D., F. A. C. P., Chief Physician at Joseph H. Pratt Diagnostic Hospital, Boston, and member of Bingham Associates
F. A. Winchenbach, M. D., Director of Laboratory, Bath Memorial Hospital, Bath
George Young, M. D., Surgeon at Redington Memorial Hospital, Skowhegan, and Surgical Director of Tuberculosis Service at Central Maine General Hospital. Lewiston

Experience and Progress of the Associated Hospital Service of Maine
Mr. Paul A. Webb, Executive Director, Associated Hospital Service of Maine

Address
Sister Belanger, Sister Superior and Superintendent of St. Mary's General Hospital, Lewiston

Address
Stephen S. Brown, M. D., F. A. C. H. A., Medical Director and Administrator, Maine General Hospital, Portland

12.30 P. M. Luncheon

Speaker: Frank H. Jackson, M. D., F. A. C. S.; Editor, The Journal of the Maine Medical Association

Subject: Hospital Publicity

Afternoon Session
2.00 P. M.

Public Relations
Allan Craig, M. D., F. A. C. H. A., Medical Director, Eastern Maine General Hospital, Bangor

Hospitals and Doctors, or Together for Others
George Pratt, M. D., Surgeon at Franklin County Memorial Hospital, Farmington, and President of Maine Medical Association

Panel: "Improving the Hospital through Elevation of Professional Standards"
Frederick T. Hill, M. D., Chairman. Chairman of Staff, Thayer Hospital, and Chairman of Committee on Postgraduate Education, Maine Medical Association
Carl M. Robinson, M. D., F. A. C. S., and Chief of Surgical Staff, Maine General Hospital, Portland
Mr. George Otis Smith, President, Board of Directors, Redington Memorial Hospital, Skowhegan; Director of Colby College; Trustee, National Geographic Society
Mr. Richard D. Hall, Director, Thayer Hospital, Waterville
Joelle C. Hiebert, M. D., Superintendent, Central Maine General Hospital, Lewiston
Alice Morse, R. N., Director of School of Nursing, Eastern Maine General Hospital, Bangor
Mr. Carroll Perkins, Attorney; Director, Thayer Hospital

Report of Nominating Committee

Report of Resolutions Committee

News and Notes

Joint Meeting

Kennebec, Penobscot, Piscataquis, Somerset

A joint meeting of the Kennebec, Penobscot, Piscataquis and Somerset County Medical Associations was held at Squaw Mountain Inn at Greenville, Wednesday, July 19, 1939.

Allan Woodcock presented a panel discussion of Fractures which he had prepared at the request of the Maine Medical Association's Committee on Postgraduate Education. Participating in this discussion were:

Carl Corson, Portland—Spine Fractures.

William V. Cox, Lewiston—Cerebro Spinal Injuries.

Howard Hill, Waterville—Diagnostic Signs as Evidenced by Visual Field and Fundus.

Forrest B. Ames, Bangor—X-ray in Fractures.

Allan Woodcock, Bangor — General Fracture Principles.

This discussion, which was ably presented, was very interesting.

George L. Pratt, President of the Maine Medical Association; Frederick R. Carter, Secretary-Treasurer; and P. L. B. Ebbett, Chairman of the Council, spoke relative to matters pertaining to the State Association.

This meeting, to which the ladies were invited, was well attended.

N. H. Nickerson, *Secretary,*
Piscataquis County Medical Association.

Maine Medical Golf Tournament

The golf tournament for members of the association proved to be a very successful affair. Over thirty members entered, and twenty-seven had their cards posted. Low gross was won by F. C. Tyson of Augusta with a score of 80. Second low gross was won by Earl S. Merrill of Bangor with an 86. Third low gross resulted in a half at 88 between C. C. Weymouth of Farmington and W. R. McAdams of Portland. The draw was won by W. R. McAdams.

The kickers' handicap resulted in a triple tie at 75 strokes net. The winner of the draw was Carl E. Richards of Alfred. Second, Frank H. Jackson of Houlton. Third, John H. Moulton of Rangeley. Suitable prizes were awarded to the winners of each group.

It is gratifying to know that physicians are interested in suitable recreation for themselves. It is to be hoped that an even greater number will enter the golf tournament during the annual meeting next year.

Annual Meeting Maine Medico-Legal Society

The annual meeting of the Maine Medico-Legal Society was held at Poland Spring Tuesday, June 27th, with the President, Oscar F. Larsen, presiding.

Attorney-General Burkett and Senator H. C. Marden and others discussed the change in the Medical Examiner Law that goes into effect January 1, 1941.

Senator Marden, Representative Peter Mills, and Attorney Benjamin Butler, were elected as honorary members.

It was voted that a committee be appointed by the President to include the Attorney-General, and to report at the next annual meeting on what should be our attitude on the situation in 1941.

Officers elected for 1939-1940 were:

President—Walter S. Stinchfield.

Vice-President—Franz U. Burkett.

Treasurer—William Holt.

Secretary—George L. Pratt.

George L. Pratt, *Secretary.*

Necrology

Thomas S. Dickison, M. D., 1868-1939

Born March 10, 1868, in Kirkland, New Brunswick, Doctor Dickison obtained his preliminary education in the Woodstock High School, graduated from the University of New Brunswick in 1890, and obtained the degree of M. D. from Bellevue Medical School in 1893 in which year he came to Houlton where he remained the rest of his life.

When Doctor Dickison commenced practice in Houlton there was no hospital north or east of Bangor, even the services of graduate nurses were rarely available and the surgery of his section and all of Aroostook was done in private homes and with assistance that today would be regarded as most inadequate. Undaunted by such difficulties, having a great interest in surgery and an aptitude for the work, he studied with care and thoroughness the available surgical literature and slowly step by step, forced by the times and conditions to learn many things by trial and error, he became in the years a safe and capable surgeon.

Impressed with the great need of a hospital in Houlton he built the Aroostook Hospital which was opened in 1906, to which for the remainder of his life he devoted a great deal of time and personal attention, and which became a corporation in 1910 composed of the physicians of Houlton and surrounding territory until 1938 when it was again incorporated as a non-profit organization. Early in its career and formation the hospital met with opposition from some who evidently were unable to appreciate the value of a community hospital to the community and the profession it served. Such an attitude bothered him little, if at all, and the results bear full well the strength of his soundness of view.

The last few years of his life, burdened by extreme sorrow and illness, he bore with stoicism and commendable fortitude. He carried on uncomplainingly to the end, but spent the last two or three years quietly with friends but always maintaining an active interest in the hospital and associated professional life. Always active in and interested in medical activities he served as president of the Aroostook County Society in 1920 and for many years was a faithful and interested attendant at the annual meetings of the Maine Medical Association. From the inception of the surgical service on the Bangor & Aroostook Railroad he was the local surgeon.

He is survived by his widow, Almatia Nelson, whom he married in 1895, and one daughter: Mrs. Jean Thalheimer. Doctor Dickison will be greatly missed in the community he served so long and well.

Notices

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Millinocket, Old Town, Portland, Presque Isle, Rockland, Rumford, Sanford, Waterville, Wilton, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Bureau of Health
Services for Crippled Children
Clinic Schedule

Bangor: *Eastern Maine General Hospital* — 1.00 to 3.00 P. M., Thursday, August 17th, September 21st, October 19th.

Fort Kent: *Normal School*—9.00 to 11.00 A. M., 1.00 to 3.00 P. M., Tuesday, August 29th.

Lewiston: *Central Maine General Hospital* — 9.00 to 11.00 A. M., Saturday, August 26th, September 30th, October 28th.

Machias: *Normal School* — 1.00 to 3.00 P. M., Wednesday, October 18th.

Portland: *Children's Hospital* — 9.00 to 11.00 A. M., 1.00 to 3.00 P. M., Monday, August 14th, September 11th, October 9th.

Presque Isle: *Northern Maine Sanitarium* — 9.00 to 11.00 A. M., 1.00 to 3.00 P. M., August 30th, October 24th.

Rockland: *Knox County Hospital*—1.30 to 3.00 P. M., Thursday, September 7th.

Rumford: *Rumford Community Hospital*—1.30 to 3.00 P. M., Wednesday, September 27th.

Waterville: *Thayer Hospital*—1.30 to 3.00 P. M., Thursday, September 28th.

N. B.: This clinic schedule is subject to change. If changes are necessary, adequate notice will be given.

A. M. A. *Indictment Quashed!*

Justice James M. Proctor, upholding a defense demurrer to indictments, ruled on July 26th that the American Medical Association and its fellow defendants were not engaged in a trade as defined by the antimonopoly statutes. Counsel for the doctors had contended their activities could not be governed by the Antitrust Law, that they were engaged in a "learned profession" rather than a trade. On December 20, 1938, a District of Columbia Grand Jury, acting on evidence presented by the Justice Department, indicted the American Medical Association, the Medical Society of the District of Columbia, the Washington Academy of Surgery, the Harris County (Texas) Medical Society and twenty-one individual physicians for violation of the Sherman Antitrust Law. These organizations and individuals, the indictment read, were "engaged in a continuing combination in conspiracy in restraint" of trade in hampering the activities of Group Health Association, Inc., for the District of Columbia, a organization established in 1937 to hire physicians and nurses and provide hospital care on a coöperative basis to government employees. Defense attorneys had contended that all their clients' activities were directed solely at the maintenance of the ethics and standards of the profession.

At the headquarters of the Association, officials, including Dr. Olin West, Secretary, and Dr. Morris Fishbein, Editor, said:

> "The principles and policies of the American Medical Association do not forbid nor have they ever contemplated any opposition to a well considered, expanded program of medical service, when the need can be established; neither is there any fundamental principle or policy which in any manner opposes aid to the indigent when indigence can be established.
>
> "The American Medical Association has always welcomed investigation by any authorized agency of the nature of its organization or of the conduct of its work or of its activities, firmly reliant in the belief that every action

taken by the Association has been in accordance with its constitutional organization in the interests of the public welfare for advancing standards and quality of medical service for the American people; and that at no time has it violated the established law of the federal, state, or municipal governments of this country. Moreover, by the very nature of its organization, it has preserved constantly the democratic principles on which the Government of the United States is founded and maintained."

Book Reviews

"A Textbook of Surgery"

(Second Edition)

By American Authors.

Edited by Frederick Christopher, B. S., M. D., F. A. C. S., Associate Professor of Surgery at Northwestern University Medical School; Chief Surgeon, Evanston (Illinois) Hospital.

Published by W. B. Saunders Company, Philadelphia and London, 1939. Cloth, $10.00 net.

Christopher's Surgery is a most excellent example of coöperative teamwork of many of America's well known teachers of medicine and surgery. 188 authors collaborated in the production of this monumental one-volume text of 1695 pages, with 1381 illustrations on 752 figures. Almost all of the surgical features included in everyday medical practice, with their many ramifications, are concisely, clearly and instructively described for the benefit of the medical student and the general practitioner. In the present edition many of the articles have been revised, rewritten, enlarged or contracted where permissible, and some new ones have been added, such as: cancer of the lip and tongne; congenital obstruction of bile ducts; duplication of alimentary tract; lymphogranuloma inguinale, tetanus and anorectal afflictions of various kinds. The various uses of sulfanilamide have been described by twelve authors. All articles are of sufficient clarity in their description of definition, etiology, pathology, symptoms, diagnosis, prognosis, treatment, postoperative care,

A CONVENIENT OFFICE TREATMENT FOR TRICHOMONAS VAGINITIS

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etc., to provide correct guidance for the physician, and the illustrations and descriptions of the surgical techniques are sufficiently detailed to permit the physician-surgeon to see his case through from beginning to end in most of the usually occurring emergencies. Even though both general surgery as well as the surgical specialties are magnificently represented, no section of the book shows a tendency to displace the specializing and highly skilled operator. All of the authors present their teachings for the purpose of attainment of better surgical results by their readers. A masterful combination of masterful teaching for a masterful medical-surgical service to mankind.

"Standard Bodyparts Adjustment Guide—Traumatic Injuries, Medical Fees, Evaluation"

Published by Insurance Statistical Service of North America, Chicago, Ill., 1939. Price, $8.00.

Even though this work was conceived by and created for the insurance interests, especially for the benefit of the compensation adjuster, it is admirably adaptable to the needs of the practicing physician. The language is essentially nontechnical, but the anatomical charts are indexed in the Latin and English terminology. Among the most important features of the book are: description of the body and its functions; medical fees, based on averages obtained in a coast-to-coast survey; specialists' fees; estimates of periods of disability and unemployability in traumatic and occupational diseases; technique of evaluation; digest of state provisions for compensation; and a medical terminology.

The work is hoped to supply a timely universal need of the medical, medico-legal and insurance professions. It would seem that every practicing physician who is likely to engage in any kind of compensation work would like to own this guide to be consulted whenever adjustment problems arise. The purchase price includes ten years of revision service.

"The Physiology of Exercise—A Textbook for Students of Physical Education"

By James Huff McCurdy, A. M., M. D., M. P. E., Director of Physical Education, Springfield College, Springfield, Mass., etc.; and Leonard A. Larson, B. A., B. P. E., M. Ed., Ph. D., Professor of Health and Physical Education, Springfield College, Springfield, Mass. Third edition, thoroughly revised. Published by Lea & Febiger, Philadelphia, 1939. Price, $3.75.

This thoroughly revised and considerably enlarged edition presents two new additions. One is a section on exercise for women, and the other a chapter on exercise for people over forty years of age. The working plan of this excellent work apparently is built up on the conclusions that "physical exercise is related to physical efficiency. The present civilization is making great demands upon the vitality of the race. School practices which train simply eye, ear, tongue and hand do not promote the health of the pupils. Laboratory work, shop work, military drill and domestic duties increase only slightly the big muscle activity. The active use of the big muscles is essential to the health of individuals. These activities are not secured in the home, on the street, or in ordinary business. Big muscles activities are essential to the development of vocational and other kinds of skill. The higher levels of the nervous system depend for their health and stability upon the organic development of the middle and lower levels of the nervous system. Big muscle activity in physical recreation is an essential part of emotional control in relation to the formation of character."

The book in its present make-up seems to be very complete, and it would no doubt be good judgment on the part of every physician, who is in any way interested in the problem of physical exercise, to consult McCurdy and Larson for further information on the subject, either directly through the text or indirectly through the very extensive bibliography which is attached to each of the fifteen chapters. The employment of stimulative and sedative drugs during training is almost universally condemned where best results are desired.

"What It Means To Be a Doctor"

By Dwight Anderson. Published by The Public Relations Bureau, Medical Society of the State of New York, 2 East 103rd Street, New York City, 1939. Price, $1.00.

This pleasingly written little book tells in the form of a modern doctor's life story some of the

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usual experiences which everyone who enters the field of medicine expects and hopes to live through. The doctor is followed from his childhood through his boyhood, his years in college, medical school, hospital training and practice. It describes in illustrative language the principal steps in the development of the successful physician and surgeon.

If this booklet could be placed in the hands of every boy who is desirous of entering the field of medicine as his life work, a great many errors of thinking would not develop, and consequently no effort would later have to be expended in the correction of such errors. Medicine has always been and must always remain a service given by one person to another person, and the type of service can and will be perfected through perfection of educational facilities, the propagation of perfected knowledge, and the selection of specially qualified men to meet the requirements of the present and the anticipated demands of the future.

"A Manual of Fractures and Dislocations"

By Barbara Bartlett Stimson, A. B., M. D., Med. Sc. D., F. A. C. S. Associate in Surgery in the College of Physicians and Surgeons, Columbia University. New York City; Assistant Attending Surgeon to the Presbytarian Hospital, New York City. Illustrated with 95 engravings. Published by Lea & Febiger, Philadelphia, 1939. Price, $2.75.

This is a handy pocket-sized, flexible cover manual on fractures and dislocations for the use of medical students and general practitioners. The author has tried to present the problem of appropriate treatment clearly and practicably with a view to satisfactory anatomic, economic, psychologic and sociologic re-adjustment. The book should receive favorable comment and ought to become a useful consultant to all those who have to treat fractured bones and injuries associated with fracture accidents. The proper technic of treatment and approximate length of immobilization for best results is given for nearly every form of injury.

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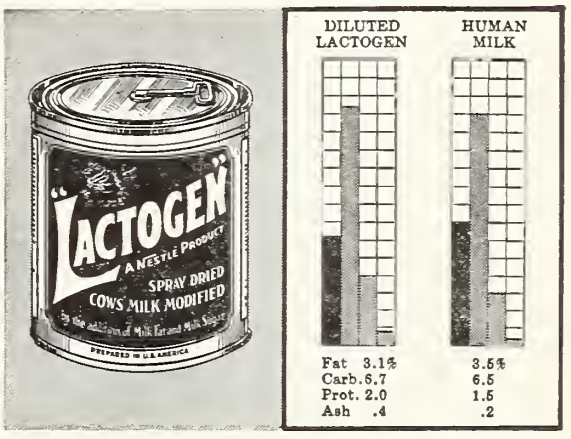

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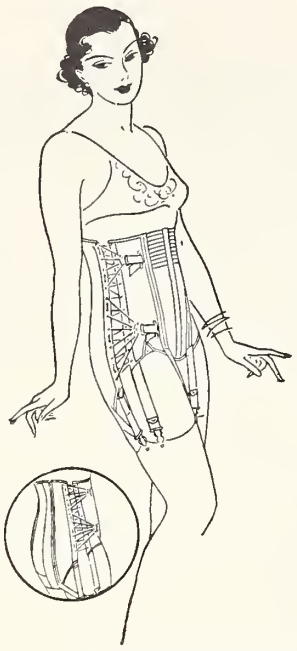

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*Hip Nailing**

By Gordon Mackay Morrison, M. D., F. A. C. S., Boston, Massachusetts

Hip Nailing has been done for years by open operation. A large incision—much shock—used only on selected cases which had to be unusually sturdy and tough to survive.

Many elderly persons were "sandbagged" —suffered continued pain for days; there was high mortality from pneumonia, bed sores and subsequent infection.

Statistics

Prior to "blind" hip nailing for intracapsular fractures of the neck of the femur, the mortality was high—25 to 30%—and bone union was low 25 to 35%.

Today, with careful and precise reduction and nailing—mortality has dropped to below 10% and bone union has risen to 75 to 80%. Some report higher percentages of good end results.

Indications

All intracapsular neck fractures should be nailed, unless the patient is actually moribund. Hip nailing is the only method by which decrepit elderly persons, may with comfort, be put into a chair the day after the operation. In these people over 80, they may be helped onto their feet and aided to walk the day after operation. With proper technique, minimal doses of *spinal* anesthesia, properly regulated, the writer has operated patients as old as 99, and had one fatality on the table out of a series of 101 cases. That one fatality was a known cardiac, and not a spinal death.

Considering that small group of patients over 80, who walked the day after operation, each got a better bony union than those treated conservatively, and they got it sooner.

This seems at first thought to be radical treatment, and to show poor judgment—but when one follows such a group—even though small—one is impressed with the possibilities presented.

Methods

Any method that is done with precision and skill, is a good method of hip nailing. Whether one uses the excellent triangular nail of Smith-Peterson, or the other methods of internal fixation, matters little—provided the operator knows his job, and does it ex-

* Read at the 87th Annual Session of the Maine Medical Association, Poland Spring, Maine, June 27, 1939.

actly. It has been our custom to wait about four days for recovery from shock and ileus which so often result. Skin traction during this interim prevents overriding and further capsular tear.

Simplicity of technique should be sought in this operation. Spinal anesthesia is preferable to ether or local because it gives the maximum relaxation for manipulation and reduction. The use of the fluoroscope on a large number of operated cases of any kind is dangerous to the operator.

A table permeable to X-rays, with a tunnel in it to place the film, without disturbing the patient is very helpful. The antero-posterior views are then taken. In order to get the lateral views some men prefer the "frog" position of flexing the thigh and outwardly rotating the leg. This method, it seems to the writer, allows motion at the fracture site—before adequate internal fixation has been accomplished. It would appear safer to have a film placed in the groin,—the good hip flexed to make room for the film—the machine properly aimed and at the proper height. Or, the reverse may be done—the tube placed in the groin—the film held behind the point of the iliac spine. The film is held so as to be flat facing the rays. With the filming as outlined—the procedure is simplified. One naturally has preoperative X-rays before the day of operation.

Manipulation and reduction is done—the leg held in marked internal rotation, and some abduction. Artificial impaction into valgus is carried out, and X-rays taken *without* disturbing the fractured leg. Films will show whether or not the reduction is satisfactory. The lateral view will demonstrate how the neck of the femur lies with relation to the table, the most important single factor in the actual nailing.

Too little internal rotation of the leg will require the entering wires or nails to climb—the neck slopes upward. Too much internal rotation will make it necessary for the wire to dive posteriorly—for again the neck is not parallel to the table.

This in itself matters not—so long as the leg is held absolutely still without the slightest degree of movement in rotation, after the lateral view has been taken. Any inattention on the part of the assistant holding the leg, will throw the operator off aim, and he will place his wire or nail too far posteriorly or too far anteriorly—probably causing him to miss the head entirely.

Skin preparation and draping is carried out.

A 3-4″ incision on the lateral surface of the leg below the trochanter, dividing fascia, is an important step, because a nail driven through the fascia lata, pinning it to the femur, may be pulled out prematurely by the outward tugging of fascia which is offset by the trochanter.

Finding a point about 1″ to 1½″ below the lower end of the trochanter—a 5½″ drill may be put into the shaft, up through the neck into the head. A second drill may be driven parallel to this—and check films may then be taken, A P and Lateral for position. If satisfactory, one drill tip is removed and there is still the remaining one to use as a directional guide for one of two or three stainless steel nails to be introduced. Generally two nails will be sufficient for strength, and they prevent rotation of the head on the neck.

There are many "directional finders" on the market—but they are not necessary if this simple technique is used.

After the nails are inserted and pounded into position with a nail set—reimpaction should be done, since rather frequently some distraction occurs.

It is our custom at this point to again check position of nails, and then to suture the divided fascia behind the nails.

A 3¼″ nail is usually satisfactory in length. Before closing the wound, careful hemostasis should be accomplished—and the subcutaneous layers sutured loosely as well as the skin itself—to avoid hematomas. A dry sterile dressing and plenty of adhesive plaster completes the procedure.

On the day after operation it is our custom to lift the patient into a chair, and to institute active exercises of hip flexion and straight leg raising. Two complications to be avoided are abduction contracture and knee flexion. These are easily prevented by abduction of the leg actively while lying in bed once or twice a day—and by seeing to it that the knee is straightened completely several times daily.

When should the average case walk?

This is a controversial question, and one that rarely fails to stimulate discussion—sometimes heated.

It has been our experience that in patients over 80 years of age it is a good practice from a systemic medical point of view—to get them up walking the next day after operation. If there is sufficient coöperative ability to walk with crutches—it is advisable to start out that way. If senility interferes with balance on crutches—then walking on the arm of an attendant is begun. Particularly in the cases of old men with prostatic difficulty, immediate early walking protects against serious trouble.

In those patients who have a life expectancy of a number of years—we have been more conservative; starting active exercises as described, the day after operation, but not allowing weight bearing for months—until X-ray films show sufficient repair to warrant weight bearing. Unless the nails have become loose and painful we have not taken them out.

Another factor worthy of consideration is that in a number of our patients—65 to 70 years of age, who have been restricted for six or more months from weight bearing, they have shown some degree of cystic degeneration in the head of the femur along the superior articulating surface of that part—evidently as a result of too sudden strain after absence of weight bearing for six months or more.

Therefore, it is probably wise to begin very slight weight bearing over a period of many weeks—in those patients who are not so old as to warrant walking the day after operation.

Conclusions

1. Nailing enables elderly patients to be up in a chair and walking on crutches within a day or two.

2. It shortens hospital stay to a week or ten days, and is of great economic advantage.

3. It lessens mortality and increases bone union.

Tuberculosis Deaths Among Young Women. The excess of deaths from tuberculosis among young women over that of males of the same age has long been regarded as an enigma by the medical profession. In an exhaustive study made in New York and Detroit, every death during one year from tuberculosis among young women was carefully investigated and several facts emerged from an analysis of the material obtained.

School life, race, nativity, participation in industrial life, insufficient clothing, poor food habits, including the ever-present dieting fads, lack of sleep and too much recreation seem negligible in their influence. The real hazard is the psychic and physical changes attendant upon adolescence and maturity. Early marriage and child-bearing increase the death rate from tuberculosis in this group.—Nicholson, E., *Study of Tuber. Among Young Women, N. T. A. Social Research Series,* No. 7.

Recovery from Tuberculosis. Much has been said and written of late years as to the relative value of the early diagnosis of pulmonary tuberculosis, but it is no less important to be sure by reliable tests that the disease is arrested. Temperature, pulse-rate, blood sedimentation and X-rays should all be utilized in coming to a decision and after there is no further progression, time should be given for the healing of the existing pathological process. Only then can the patient be assured that recovery has taken place and that recurrence is unlikely under the ordinary stresses of life.—Green, J. W., *Med. Bull. Vet. Adm.,* Jan., 1936.

On one point there is no longer debate. The need of medical and social supervision for arrested cases of tuberculosis over a prolonged period is clearly indicated. It is the only insurance against failure regardless of whatever procedure is adopted in the individual case.—*Nat'l Tuber. Assn. Ann'l Rep.,* 1938.

*Traumatic Shock**

By Franklin G. Balch, Jr., M. D., Boston, Massachusetts

In this paper I shall not present to you any new or original work on traumatic shock. I shall try, however, to give you the present conception of shock and the best form of therapy.

Shock can be divided into two types, primary and secondary. The primary type is essentially one of collapse coming on suddenly as after a severe blow. It is not this type with which we are concerned. I think all of you are familiar with the patient showing secondary shock. His skin is cold, clammy and dusky; his pulse thin, thready and rapid; his respirations shallow, feeble and frequently interrupted by sighs. Thirst is often present but frequently associated with nausea. The outstanding feature is a blood pressure 75 mm. Hg. or below. The mind is frequently clear. This picture may present itself after small or large hemorrhages or after moderate or severe injuries. It does not occur immediately but is a later manifestation.

Laboratory studies show that these patients have a lowered metabolism, a high hemoglobin reading, an increase in blood sugar and NPN with a decrease in blood chlorides and CO_2 combining power.

Theories As To Low Blood Pressure

Cannon[1] states that "three factors may be concerned:

(1) Weakened vigor of the heart.

(2) A lessening of vasomotor tone so that the capacity of the vascular system is greater than its content and the blood is, therefore, not held under normal tension.

(3) The obverse of this, a reduction of blood volume below the minimal capacity of the vascular system so that again the capacity is greater than the content."

Let us look into these causes in greater detail.

(1) Weakened cardiac vigor. No experimental evidence has been brought forward to prove that the cardiac action is impaired[1]. There is, therefore, very little value in the use of cardiac stimulants. Digitalis is of no value. Epinephrin is in fact contraindicated due to its constricting action on the arterioles. Caffeine may be of slight value.

(2) Lessened vasomotor tone. Cannon[3] states that "there are numerous observations, also, which prove that in the early stages of shock, when the blood pressure is falling, the peripheral vessels are constricted instead of being relaxed." He adds that in prolonged instances of relative anemia, the venous cells may be damaged which, of course, will cause an eventual loss of vasomotor tone.

(3) Reduced blood volume. Most observers agree that this is the important factor in a lowered blood pressure but there is no unanimous agreement as to why this occurs. All agree, however, that hemorrhage will reduce the blood volume which, of course, explains why the symptoms of shock and hemorrhage are so closely alike.

Keith[2], during the World War, showed that the volume of circulating blood might be lowered from 15% to 50% in shock. If it were lowered more than 35%, the prognosis was very grave.

Cannon[1] in 1923 advanced the theory that some toxic substance having a histamine-like action was liberated from the wound. This has not been demonstrated by Smith[4], and Parsons[5] and Phemister. Blalock[6] et al have also disagreed with this toxic theory. He believes that a loss of blood into the adjacent tissues is an important factor. O'Shaugnessy[7] from his experimental work feels that "a toxemia due to the elaboration of histamine plays no part in the syndrome of traumatic shock." He believes that "too little attention has been paid to the nervous side," advocating the use of spinal anesthesia. Fear, pain, cold, all favor the production of shock. Cannon, Freeman[8] and others have shown that prolonged sympatho-adrenal hyperactiv-

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ity may lessen the quantity of circulatory blood. By what means this is brought about is somewhat uncertain.

Coonse[11] and his co-workers have done considerable experimental and clinical research concluding that shock from acute hemorrhage and shock from trauma or slow hemorrhage differ essentially. In the former no acidosis exists while in the latter it is an important factor. They believe that "not only is there a loss of circulatory blood volume, but that the acid base balance undergoes a striking change toward the acid side." They believe that with loss of tone there is increasing anoxemia which in turn damages the vessels allowing the escape of essential salts and protein.

From this short résumé as to the causes of shock, you have undoubtedly come to the conclusion that there is no one single cause of shock. Be it due to toxemia, lessened vasomotor tone, reduced blood volume or increased psychic stimuli, the one outstanding feature is a lowered blood pressue.

Prevention

Let us now turn our attention to what can be done to prevent shock. We are particularly interested in that type following accidents associated with fracture. It was dramatically demonstrated that a marked drop in mortality occurred during the World War following the use of the Thomas and Jones splints. These with slight modifications are of just as much value today as they were some twenty odd years ago. All hospitals and first aid stations should be equipped with these. Moreover, any doctor called upon to do much traumatic work should carry with him a leg and arm splint. These have been rather expensive in the past, costing about $10 to $15 a pair. It is hoped, however, that a set can be made minus any frills selling for between $6 and $8 a pair. It is needless to say that an adequate control of hemorrhage is essential as a preventive.

Treatment

The replacement of lost blood volume is the most urgent requirement. Blood transfusion is the most satisfactory medium. In its absence 1000 c.c. of 10% glucose in saline may be employed intravenously at the rate of 1 to 10 c.c. per minute. This is but of transient use as it rapidly diffuses from the blood vessels. If continued, this may wash out some of the plasma from the blood. This solution is put up in sterile flasks by several drug houses and is available for emergency use in the office or home.

Coonse has advocated the use of sodium bicarbonate in 5% strength to combat acidosis and has reported very gratifying results both experimentally and clinically. He does not believe that inhalation of CO_2 is effective.

Morphia in adequate dosages is effective if given early in delaying or minimizing the further progression of shock by lessening painful stimuli. It should *not,* however, be used in advanced cases where it will lower the vitality of centers already markedly depressed.

Heat is a very valuable method of treatment. It serves a dual purpose, (1) by preventing further loss of heat from the stagnant peripheral circulation, (2) by improving the normal physiological processes dependent on an adequate temperature. The Massachusetts General Hospital has a special table heated by water with a mechanism for lowering the head. All patients in shock or suspected of shock are placed on this table.

Several years ago there was a good deal of enthusiasm concerning gum acacia as a substitute for blood. During the World War this was advocated in the treatment of shock as it would remain in the blood stream. Due to impurities, however, there were many fatalities so that its use fell into disrepute. There have been reports of its successful use with the more pure forms. Huffam reported its use in 3,000 infusions at the Mayo Clinic between 1926 and 1932 with one unfavorable result. This was a 6% solution in normal saline. Andersch[9] and Gibson of the University of Iowa showed in animals that 30% to 50% was deposited in the liver with a diminished output of bile salts and bilirubin. More recently Studiford[10] has reported on its use on the obstetrical and gynecological service at the Bellevue Hospital in New York. He reports several cases characterized "by cyanosis, dyspnea, tachycardia and pulmonary edema." In two autopsies the liver was practically destroyed. He employed 6% acacia in 20% glucose. It has been used occasionally at the Massachusetts General Hospital and the Boston City Hospital. As far as I have been able to determine, it has not been

used at the latter institution during the last few years and only once at the former during the past year. This was for a severe hemorrhage when no immediate donor was available. It has also been shown that acacia increases the resistance of red cells to hemolyzing agents, reduces the oxygen carrying capacity and increases rouleaux formation.

From this discussion you will conclude that gum acacia in 6% solution in saline is of use in an emergency when blood is not available. Otherwise, it should not be used in the treatment of shock.

Transfusion

Blood transfusion is agreed by all to be the best method of combating shock. This not only increases the fluid volume but also increases the oxygen carrying capacity of the blood stream. Above all it will not permeate through the blood vessels. Formerly we gave this by the whole blood method using the Vincent or Kimpton paraffin tubes. This method has been abandoned for the use of citrated blood which is a far simpler technique and can be carried on with the minimum of worry, hurry and equipment. At the Faulkner Hospital practically all of these are given by the House staff. Recently one of the drug houses has come out with a flask of citrate which contains enough vacuum to draw in 500 c.c. blood. We have had no experience with this but it should be quite ideal. Lundy[12] reports 3,295 citrate transfusions from the Mayo Clinic in 1938 in most instances using groupings only. He reports fairly severe reactions in 4.0% of cases.

A few suggestions as to technique may be not amiss at this point.

(1) Cross matching. We believe that the donor and recipient should be grouped and in addition to this, that the donor's cells should be directly matched with the recipient's serum, Hanging drop preparations should be used, not cover glasses on a flat slide. This should be observed if possible about 45 minutes.

(2) Diet of donor. Transfusion should not be done immediately after the donor has had a meal as it is thought that some reactions may be due to protein sensitivity.

(3) Wassermann test. This, of course, should be done on all donors.

(4) Refrigerated blood. We are accustomed to using the blood immediately. Lundy reports that in 1938 "40.7% of all transfusions refrigerated blood was used and in 59.3%, fresh blood." He states that reactions were a little less frequent with refrigerated than with fresh blood.

(5) Blood banks and cadaver blood. We have had no experience with this technique. They have been reported as being successful.

Whatever the cause of secondary shock and whatever form of therapy we employ, let it be employed soon enough. Don't wait until the blood pressure has "dropped out of sight." Start therapy when it is around 90, not when it is 60.

Summary and Conclusions

(1) The cause of shock is not known. There are probably several. The following theories have been advanced:

- (a) Toxemia.
- (b) Decreased vasomotor tone.
- (c) Reduction of blood volume.
- (d) Acidosis.

(2) It may be prevented by

- (a) Proper use of splints for fractures.
- (b) Proper use of heat and morphia.

(3) It is best treated by

- (a) Transfusion.
- (b) Intravenous fluids such as 10% glucose in saline or 5% sodium bicarbonate.
- (c) 6% gum acacia in saline.

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*Anesthesia for Traumatic Surgery**

By Dr. Sidney Cushing Wiggin,† Boston, Massachusetts

Much has been written about anesthesia for the surgical patient in elective surgery, but little has been said about the care of the traumatic surgical patient. Traumatic surgery is that branch of surgery which deals with those injuries produced by violence. This group is large and increasing in scope because of the modern trend in transportation by air, land, and water, the ever increasing injuries in the world of sports, and battle, and also because of the increasing number of accidents in the home. These real emergencies, are cared for at the large city institutions, or by the community hospitals. These hospitals today should be equipped with a fully trained personnel to handle every detail of the treatment of these cases. This technique should include not only surgeons with special training in traumatic surgery, but also physicians trained in anesthesia. Every hospital handling this type of patient should be staffed with an anesthesia department empowered with the same authority as the rest of the staff. In the hospitals of the larger cities the anesthetist supervising the department of anesthesia should be a qualified specialist in anesthesia with graduate physician anesthetists as assistants. In the smaller city or community hospitals, sufficient staff members should be in charge of anesthesia, having previously had special training before assuming the supervision of this department. In this manner every hospital throughout the country would have an efficient anesthesia service, and one equipped in the modern methods of anesthesia for the traumatic surgical patient.

The acute traumatic emergency usually shows varying degrees of shock as the result of the combination of trauma to the central nervous system, loss of blood and tissue damage. For this reason they require much more attention for anesthesia than the patient seen in elective surgery. They may even exceed the seriousness of the acute abdomen, one of the commonest surgical emergencies. Organized efficient care of these patients will eliminate unnecessary pain and suffering, better detailed treatment of the injuries by unhampered surgeons, support of the patient's vital functions before, during and after surgery, prevention of post-operative complications with a more rapid and uneventful convalescence and better end results.

The first consideration in the care of the traumatic surgical patient for anesthesia is the classification of these cases into good, border line, and bad risks. By being fully acquainted with the risk of the patient, the anesthetist is able to prepare the patient more intelligently for anesthesia and operation by a wise choice of premedicating drugs and anesthetics. In this manner, the condition of the poorer risk is supported and improved at all times, so that the patient is more able to stand the operation and will have a better convalescence.

The good risk patient is one who has a local injury with no complicating pathological conditions. The border line risk patient is one who has a severe injury and minor pathological complications or vice versa. The bad risk patient is one who has a severe injury and serious pathological complications. In order to arrive at these conclusions, a complete history and physical examination, which should include blood pressure, pulse, and respirations; and laboratory tests, which comprise X-rays, urinalysis and blood test if indicated.

Of prime importance is the consideration of the patient's psychic state which is controlled with words of encouragement, suggestion, and drugs. From all this data the anesthetist makes his choice of drugs and anesthetics, also the method of administration of the anesthetic.

The drugs used for premedication are morphia and atropine for ether and avertin anesthesia; morphia and scopolamine for nitrous oxide and oxygen anesthesia; nembutal, morphia, and scopolamine for spinal or regional

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anesthesia; and nembutal, morphia, and atropine for cyclopropane, G. O. E., and pentathol anesthesia. The dosages of these drugs are regulated according to the age, size, emotional state, and physical condition of the patient as found on examination. In the good risk patient the average dosage is adequate. In the border line patient the dosages are reduced according to the condition of the patient. In the bad risk patient premedication should be eliminated or given only in very minimum amounts.

The choice of anesthetics for these cases are again based on the classification of the patient's condition, whether good risk, border line, or bad risk. In compound skull injuries, in good risk patients, avertin (60 to 80 mgms. per kilo of body weight) is supplemented by ether and oxygen which is administered, through an intratracheal tube, in order to prevent any respiratory depression and also to allow for artificial respiration with oxygen if needed. In border line risk cases, avertin is supplemented with local anesthesia, but oxygen should be available through a nasal tube or oral airway. In the bad risk head case, which is presumably in coma, local anesthesia alone may suffice; if the patient is restless, fractional doses of pentothal sodium can be administered through the intravenous tubing, thus keeping the patient under complete reflex control. In injuries involving the respiratory tract or mouth complicated by blood and foreign bodies, intratracheal cyclopropane oxygen or avertin and intratracheal ether with oxygen is used. Cyclopropane is administered intratracheally or through a special oral airway such as the Leech airway for external injuries to the face. Pentothal-sodium intravenously can be used to good advantage for the shorter operations about the face or mouth in the good risk patients. Cyclopropane, or nitrous-oxide-ether, is used in injuries about the neck or shoulder joints. Injuries of the arms and hands may be handled with cyclopropane-oxygen, brachial plexus block, or field block. For injuries to the chest, cyclopropane-oxygen is the anesthesia of election because of the high oxygen available to the patient with a lowered vital capacity, also to make it possible to administer the gas and oxygen under positive pressure, in order to prevent pneumothorax or dam back secretions in the bronchi. Spinal injuries are best handled with nitrous-oxide-oxygen-ether or cyclopropane-oxygen intratracheally, with special precautions being taken to support the shoulders and pelvis on pillows to relieve interference with diaphragmatic excursions, thus preventing respiratory depression and shock from pressure on the abdomen. In the traumatic abdomen or lower extremities, spinal anesthesia is elected in good risk cases, and balanced spinal anesthesia in the border line risk cases. Balanced spinal anesthesia consists of premedicating drugs combined with minimal doses of the spinal agent or agents and supplemented with inhalation cyclopropane - oxygen, nitrous-oxide-oxygen or ether-oxygen, maintaining a high concentration of not less than 500 c.c. of oxygen per minute. Local anesthesia with novocaine and gas-oxygen is the anesthesia of election in the bad risk abdominal and lower extremity case.

In operations about the hip joints, as nailing of fractures of the neck of the femur, where the patient usually falls into the age group of 60 to 100 years, and is in the good or border line risk class, spinal anesthesia is used with minimal amounts of the agent. In the extreme age group, as little as 30 mgms. of novocaine and 3 mgms. of pontocaine is all that is needed. This anesthesia will last from 1½ to 2 hours. In the bad risk patient nitrous-oxide-oxygen and local infiltration with novocaine is the safest procedure, keeping the oxygen at a maximum concentration.

Pentothal-sodium intravenously is ideally adapted for anesthesia in the short operation as reduction of simple fractures and dislocations or suturing of lacerated wounds.

The complications from injuries found in the traumatic surgical patient differentiate this type of patient from the average anesthetic problem in surgery. The most common conditions complicating anesthesia in these cases are coma, excitement, alcoholism, shock, hemorrhage, sepsis; the presence of a full stomach, nausea, and vomiting; obstructed airways from fractured jaws and teeth; impairment of respiration from severe neck, chest and spinal injuries; such injuries as compound fractures and dislocations, and spinal injuries.

In the unconscious patient a very careful

history should be obtained from a responsible person. If this is impossible, a very complete physical examination and laboratory tests should be made to rule out other causes for the coma than direct injury. In head injuries unconsciousness in varying degrees is common and the anesthetist must be careful in his choice of anesthetic.

The excited patient usually can be reasoned with and by the power of suggestion and with the aid of hypnotic drugs can be controlled. The alcoholic patient is a real problem for anesthesia, especially when complicated with severe injury. When alcoholism is proven to be present a gastric lavage should be done immediately, and as there is usually present in the alcoholic, varying degrees of cerebral edema, no morphia should be given. Very often delirium tremens develop during operation under anesthesia or immediately post-operatively. For this reason it is best to eliminate ether if possible. Spinal anesthesia is the anesthesia of election, if indicated. At the time of administration it is well to withdraw about 20 c.c. of spinal fluid to relieve intracranial pressure.

Paraldehyde given rectally, in dosages of 15 to 30 c.c. per 100 pounds of weight, mixed with starch, ounces 1, and water ounces 5, for hypnosis or as a basal anesthetic to be supplemented by the gases, preferably nitrous-oxide-oxygen, as paraldehyde is not well adapted to the closed CO_2 absorption system. The smaller doses of paraldehyde are used for the debilitated, depressed and obese.

The degree of shock should be determined and treated with the usual methods before operation is considered unless it is imperative to perform an immediate operation. Also the degree of hemorrhage should be determined by blood pressure, pulse, and general condition of the patient, and if severe, transfusion should be given.

If the patient is in the border line risk class, and has not needed intravenous fluids and transfusions, but shows varying degrees of moderate shock, as a prophylactic measure it is well to administer intravenous fluid (glucose 5% in normal saline) with the beginning of the operation and have a transfusion of blood ready for immediate use if necessary.

Too many patients have died from aspiration of vomitus under anesthetics. This is a fact which is more common than generally believed. If it is known that the patient has a full stomach a gastric lavage should be done. If inhalation anesthesia is elected; it should be administered intratracheally. If the patient is unconscious and unable to tell his story, and the intratracheal method is not employed, he should be carefully watched while under anesthesia for any occurring vomiting and treated immediately. The anesthetic should be removed immediately and the patient allowed to empty his stomach if possible or a stomach tube inserted to eliminate any liquid vomitus. Direct intubation should be done with a laryngoscope and tracheal suction should be instituted. Spinal anesthesia should be used when possible to prevent the dangers of vomiting.

If the patient vomits during anesthesia, whether he shows any signs of obstruction or not, he should be bronchoscoped immediately in order to prevent postoperative pneumonia or atalectasis. If the hospital does not have an expert bronchoscopist on the staff, the anesthetist should perfect his technique in this procedure.

Foreign bodies in the mouth should always be looked for as they may be the cause of obstructed airways. Trauma of the trachea or chest wall, or injury to the upper spine should be investigated as a cause of impairment of respiration.

Excessive secretions of the nose, pharynx, or respiratory tract may be the cause of obstructed airways. In the case of fractured jaws or teeth, careful examination should be made for loose particles and blood clots. If foreign bodies are suspected in the lower respiratory tract bronchoscopy should be performed. This type of complication calls for the use of the suction apparatus in the naso-pharynx, oro-pharynx, and trachea. Cyclopropane-oxygen administered intratracheally should be used where these conditions complicate the normal respiratory exchange.

In fractures of the spine and compound fractures, these parts should be thoroughly protected and splinted and the patient handled properly to prevent any further damage to these regions while undergoing anesthesia.

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Tracheotomy — The Bronchoscope as an Aid in Emergency Cases

Edward L. Pratt, M. D., F. A. C. S., Lewiston, Maine.*

Tracheotomy is a comparatively simple operation when it can be done in a planned and orderly manner. In extreme emergencies the only instruments needed are a pair of hands and a knife. If the hands are trained and one has memorized the Jackson technic, it can be, and has been, successfully done in the dark (1). But neither this knowledge, nor the fact that tracheotomy has become a relatively rare operation, is any excuse for the lack of a complete sterile tracheotomy set being at all times available for instant use in all of our hospitals.

A survey of a considerable number of hospitals in our smaller cities and towns finds them either totally lacking in proper equipment for an emergency tracheotomy, or having only a partial, makeshift equipment which is usually scattered about in various cabinets rather than assembled as a unit. Often there are not more than two sizes of tubes available—sometimes only one. These are often of ancient vintage and unscientific design. Many were purchased from the surplus stock of the U. S. Army Medical Corps, circa 1919-1920. They are made of aluminum or an alloy resembling it; they are too short, have not the proper curve; have ill-fitting cannulae, and have no pilots. Rarely were duplicate tubes available.

Unlike many other emergency operations, it is often a matter of seconds rather than minutes, which count when an emergency tracheotomy has to be performed. Extreme dyspnoea, whether due to an inflammatory obstruction or an impacted foreign body in the trachea, cannot wait upon a search of instrument cabinets for the proper instruments and their sterilization after they are found. They should be assembled as a unit, wrapped up in a sterile tray or towel and labeled "Emergency Tracheotomy Set." This set should be instantly available at all times, day and night. Each set should contain the following:

1 scalpel and 1 sharp curved bistoury
6 curved mosquito clamps
4 Kelly clamps
2 smooth retractors
1 tenaculum (useful in steadying and elevating the trachea)
1 pair of dissecting scissors
1 pair, narrow, curved on the flat scissors
Trousseau dilator
2 curved needles
1 needle holder
2 tubes No. 0 catgut
Hypodermic syringe for local anæsthesia
2 ampules of 1% Novocaine
6 sizes of Jackson tracheal cannulae with pilots
Linen tape 1 inch wide to tie the cannula
2 soft rubber catheters (10 F.) for aspiration

The importance of having tracheal cannulae of proper curve and correct length cannot be emphasized too strongly. "Untold thousands of deaths have occurred from improper makeshift cannulae" (2). Unfortunately, there are scores of different models of tracheotomy tubes, each differing in curve, calibre and length. A tube of one make numbered 4, for example, will be found to be of the same size as one numbered 6, of another make. The curve of a tube manufactured by X Company will be found to differ markedly from a tube manufactured by Y Company. The same is true as regards their length. It is therefore of the utmost importance that a duplicate set of cannulae of the same model and made by the same instrument maker, should always be kept at hand. The Jackson cannulae made by Pilling & Sons of Philadelphia, like the O'Dwyer intubation tubes, have stood the test of time.

Every tracheotomy case requires two cannulae; one to replace the original tube when it has to be removed and cleaned. These cannulae should remain the property of the hospital. If the patient is to be discharged from the hospital while still wearing a cannula, two cannulae of the same size and make should be obtained for him so that the hospital sets remain unbroken.

* From the Department of Broncho-Esophogology, Central Maine General Hospital, Lewiston, Maine.

The technic of the operation need not be described here as it can be found in any standard surgical treatise. Every surgeon should memorize Jackson's technic of how to perform the operation in great emergencies, even in the dark (3). Attention is also called to an error which still persists in many surgical works, namely, that there are two kinds of tracheotomy—high and low. Every tracheotomy should be a low tracheotomy; that is, below the second tracheal ring. In rare cases, in order to prevent death by asphyxiation, it may be necessary to make an opening through the crico-thyroid membrane, but this should always be followed, not more than 48 hours later, by a tracheotomy below the second ring. Unless this is done, a perichondritis with a resulting stenosis of the larynx is sure to follow.

That the bronchoscope can be of great value in cases requiring emergency tracheotomy, is well illustrated by the following two cases:

Case I. Miss M. Hosp. Case No. 76485. Admitted to the Central Maine General Hospital November 8, 1938. Age 3½ yrs.

Present Illness: Patient had had a sore throat for a week before a physician was called. He discovered that the child was hoarse and that there was an extensive membrane covering the pillars of the fauces and extending on to the soft palate and the posterior pharyngeal wall. He sent her at once to the hospital.

Physical Examination: On admission the patient looked very ill. She was extremely dyspnoeic, with indrawing of the supraclavicular, suprasternal and epigastric spaces. There was a marked expiratory stridor. She had an ashen grey color, an anxious expression and was very restless. A dirty grayish-black membrane covered both tonsils, most of the soft palate and extended down the pharynx as far as could be seen by depressing the tongue. A diagnosis of faucial and laryngeal diphtheria was made. The child was admitted to the isolation ward for an immediate tracheotomy. Because of the extreme dyspnoea and restlessness and because the child had a short fat neck, it was decided to bronchoscope the child and do the tracheotomy with the bronchoscope in the trachea. A 4mm. Jackson bronchoscope was passed into the trachea and with an airway established, an orderly tracheotomy was performed. The wisdom of this procedure was demonstrated at operation when the trachea was found to be covered with a deep layer of fat, and the two inferior thyroid veins—almost as large as a lead pencil—all but covered the anterior surface of the trachea. Had the operation been performed without first providing a good airway, the haste essential for the relief of the extreme dyspnoea almost certainly would have resulted in injury to these greatly congested veins, and a fatal haemorrhage might have ensued.

Case II. L. R. Male, Age 7 yrs. Hosp. Case No. 76612. Admitted to Central Maine General Hospital November 22, 1938.

Present Illness: Two weeks before admission the parents noted that the boy was hoarse. A physician was called who prescribed some medicine and the boy seemed to improve somewhat, but a week later the hoarseness had increased. Tinct. of Benzoin inhalations were prescribed and given for the next 48 hours but they failed to relieve the hoarseness. About 12 hours before admission the boy became aphonic, began to vomit, choke and gasp for breath. He became very cyanotic and was rushed to the hospital, 20 miles from his home.

Physical Examination: On admission he appeared very ill. He sat up on the stretcher using all his accessory muscles of respiration. There was indrawing of the suprasternal, supraclavicular and epigastric spaces. He had an ashen gray color, dilated pupils and an anxious expression. No membrane was seen in the oropharynx but there was a dirty grayish exudate in the hypopharynx and the larynx. He was admitted to the isolation ward for an emergency tracheotomy. As in the first case, the dyspnoea and restlessness was so marked that it was thought best to pass a bronchoscope and do the tracheotomy with the bronchoscope in the trachea. A 6mm. Jackson bronchoscope was passed into the trachea and an orderly tracheotomy was per-

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President's Page

To the Members of the Maine Medical Association:

The Wagner Act proposes a revolutionary change in the provision of medical and hospital care.

Why should there be such a change?

At the hearing on the Act, Dr. Haven Emerson of The New York City Board of Health stated: "No emergency of sickness or neglect faces us."

Dr. R. G. Leland, Director of the Bureau of Medical Economics of the American Medical Association, said that according to official vital statistics, constant and continuous improvement in the health of the American people had been in progress for many years.

These statistics showed general improvement in mortality rates except for cancer, diabetes, and diseases of the heart and blood vessels.

The reason for the increased rates in these diseases being that more people lived long enough to develop them.

The figures of Dr. Louis I. Dublin, statistician of the Metropolitan Life Insurance Company, show that in 1880 the average expectancy of life at birth in the United States was 40 years. In 1938 it had risen to 62 years.

In 1938 over 98% of the people in the United States lived within 30 miles of a registered hospital.

There were 6,166 registered hospitals with 1,161,380 beds.

In the general hospitals there was a daily average of 132,454 empty beds.

The number of beds in the general hospitals is increasing at a rate greater than that of population increase.

Would it not seem sensible to more fully utilize existing facilities before embarking upon an enormous new construction program as contemplated in the Wagner Act?

Do the records of the various European systems of State or socialized medicine indicate that they offer to the American people any advantages over our present system?

They do not.

Who are back of the proposal to change so radically the American way of practicing medicine and running hospitals?

Dr. Arthur W. Booth, Chairman of the Board of Trustees of the American Medical Association, at the hearing, stated: "So far as I am informed, no evidence has ever been offered to show that any of the projects embodied in S. 1620 were devised by any of the people of the several States, or that enactment of this legislation is being promoted by them.

On the contrary, it is understood that every project embodied in this bill was devised by appointive federal officials and employees, to be handed down to the people on a 'take it or leave it' basis."

The familiar characteristics of the New Deal philosophy are again demonstrated.

George L. Pratt,
President Maine Medical Association.

President's Page

Collection agencies have been heard from again.

Every member of the Association knows, or should know, of Dr. Gehring's work on these agencies. The President's Page of July, 1934, should be printed every year, and every member should study it.

G. L. Pratt,
President Maine Medical Association.

Stop * * Look * * Listen

TO THE MEMBERS OF THE MAINE MEDICAL ASSOCIATION:

NEVER SIGN EITHER A CONTRACT OR A NOTE WITH ANY COLLECTOR'S AGENCY, IN-STATE OR OUT-OF-STATE, *NO MATTER BY WHOM SUCH AGENCY IS RECOMMENDED.* ANY SOLICITOR OR AGENT WHO WANTS YOUR ACCOUNTS FOR COLLECTION SHOULD AROUSE YOUR SUSPICION AT ONCE IF HE ASKS FOR YOUR SIGNATURE EITHER TO A NOTE OR A CONTRACT. LEGITIMATE COLLECTION BUSINESS DOES NOT HAVE RECOURSE TO NOTES OR CONTRACTS.

FAILURE TO APPRECIATE THE FOREGOING IS RESPONSIBLE YEARLY FOR THE LOSS OF THOUSANDS OF HARD-EARNED DOLLARS TO MAINE PHYSICIANS.

IN THE FUTURE, BEFORE YOU PLACE ANY ACCOUNTS FOR COLLECTION WITH *ANYBODY*, WRITE THE SECRETARY OF YOUR STATE ASSOCIATION FOR INFORMATION CONCERNING THE PERSON OR FIRM IN QUESTION. TO RENDER SUCH SERVICE TO OUR MEMBERS IS ONE OF THE DUTIES OF OUR COUNCIL. MOREOVER, TO RECEIVE SUCH SERVICE IS ONE OF THE PRIVILEGES WHICH MEMBERSHIP IN A COMPONENT COUNTY MEDICAL SOCIETY CONFERS.

REMEMBER! SOLICITORS OR AGENTS OR COLLECTORS ARE MORE OR LESS CONSTANTLY IN OUR MIDST. THEIR SCHEMES FOR GETTING MONEY WHERE OTHERS, INCLUDING YOURSELF, HAVE FAILED, ARE INTRIGUING AND LEGAL. HOWEVER ALLURING THEY MAY SOUND, IF THEY INVOLVE THE SIGNING OF A CONTRACT OR A NOTE, REFUSE TO CONSIDER THEM ALTHOUGH THEY MAY BE SPONSORED BY GROUPS OF PHYSICIANS OR CHAMBERS OF COMMERCE.

IN EVERY INSTANCE, CONSULT YOUR STATE ASSOCIATION'S SECRETARY AND HAVE YOUR EYES OPENED, BUT DON'T SIGN A NOTE OR A CONTRACT.

E. W. GEHRING.

Editorial

The Address of Senator Robert A. Taft

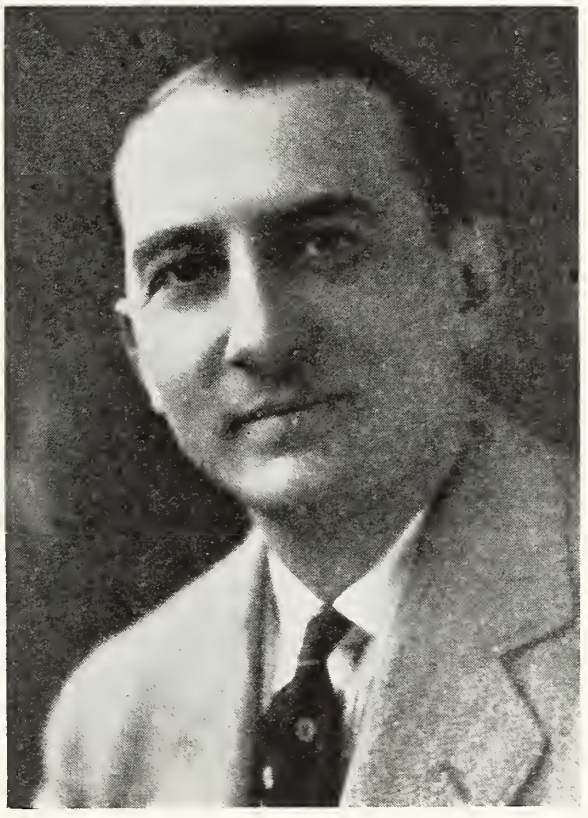
The Journal of the A. M. A., issue of July 29, 1939, prints an address given by Senator Taft at the laying of the corner stone of the Doctor's Hospital in Washington on July 11th, which contains many remarks on the subject of socialized medicine and attempted government control most worthy of study and thought. Senator Taft as a member of the sub-committee of the Senate that heard the arguments concerning the Health Bill proposed by Senator Wagner of New York is also in the position, as a member of the bar, to point out the inherent dangers of the measure as it is proposed. While the views expressed in this address are in direct opposition to those presented not long ago before the House of Delegates of the American Medical Association by the late Senator J. Ham Lewis, who openly advocated the control of the profession of medicine by the Federal government, they contain many thoughts of great concern — concern not only to the members of the profession of medicine, but to every other profession and to the people of this nation as a unit.

Stating in his opinion that the present Wagner Bill will not be pressed at this session, he does feel that in 1940 a *federal* program of some kind will be adopted. "What form it takes depends largely on the medical profession," and he expresses the hope, which is probably father to the wish, that the medical profession will, through its National and State Societies, determine the program that can be adopted to improve the health of the American people and the practical measures as to how that program shall be assisted and made to work.

Calling specific attention to the needless complications of the Wagner Bill, he points out that every State adopting the plan will have *six* separate divisions, with an advisory committee for each plan, and for the country as a whole there will be some *three hundred different boards largely composed of laymen.* Any federal health program should, he states, be consolidated under one head, and each State program, as far as is possible, should be under a single State department. He also agrees with the opponents of the bill that while a specific program for socialized medicine is not contained at present, it is definitely proposed by those who favor such a measure and who regard the bill as a vehicle to put into effect that which will most definitely accomplish the purpose they have in mind.

Emphasizing the hope that the unequaled medical service that is received by and is available to most Americans can and will be extended so that all who are inclined can obtain it, he feels without question that if the profession shows the interest and participation that it should, it will make certain the fact that the health and welfare of the people will not be "dominated by half-baked theorists and those who believe in a totalitarian state" and that a Federal aid program can and will be worked out which will be much simpler, decidedly more economical and also will preserve the essential independence of the individual members of the profession which cannot be possible under the Wagner Bill. Professional independence means far from advocating any trade union principles which can have no part in a profession practised as a profession, but one must contemplate, with dire misgivings, the hope that a professional status would obtain under the bill proposed by Senator Wagner.

Necrology



Henry Sprince, M. D.,
1898-1939

Born August 15, 1898, Paris, France. Died Friday, August 4, 1939. He practiced medicine in Lewiston for fourteen years and was throughout this period a member of the Staff of the Central Maine General Hospital as Assistant Surgeon and in 1935 received the additional appointment as Assistant Obstetrician.

He came from France as a small boy, attended the Lewiston High School and will be remembered by that school as the author of their official school song, "L. H. S. Forever." Dr. Sprince entered Bowdoin College in the fall of 1916. In 1918 he enlisted in Infantry and served until Armistice was declared, returning to Bowdoin where he completed his courses and was graduated in 1920. During his student days at the Bowdoin College he wrote the famed "Polar Bear" song. In the fall of 1920 he matriculated at the Bowdoin Medical School until it was discontinued, and completed his medical studies at McGill University College of Medicine. In 1923 he interned at the Kings Park Hospital at Long Island, New York, and the following June became House Physician at the Central Maine General Hospital for one year, after which he assumed his practice in Lewiston.

Dr. Sprince was at all times a student as well as a practitioner of medicine. In his earlier years he demonstrated a keen interest and broad understanding of endocrine disturbances. As a result of this interest in endocrinology he was awarded a Bowdoin Scholarship in 1930 and spent six months in the Lying-in Hospital, Kemp Park Hospital and at the Clinics of Dr. Mazer in Philadelphia, concentrating in endocrines and their relation to gynecological disturbances. For the last four years Dr. Sprince was awarded Bingham Fellowships in endocrinology at the Massachusetts General Hospital and the New England Medical Center.

Dr. Sprince was a versatile musician. At Bowdoin he was the leader of the Banjo Club and conducted his own orchestra at various summer resorts. In a Glee Club concert under the auspices of Bowdoin College he presented his own jazz version of the "Peer Gynt" suite under the title of "Peter Gint." Lewiston was charmed by his entertaining talents, particularly as a tenor in the Parker Glee Club, and he was widely applauded for his unusual skill in the conduction of various operettas.

The Doctor was a member of the Androscoggin County Medical Society and a Fellow of the American Medical Association, a member of the Masonic bodies and the Shrine, of the local Kiwanis Club, B'nai B'rith, and of Beth Jacob Synagogue.

He was married in December, 1924, to Miss Normal Rothschild of Montreal.

He is survived by his wife and a son, Richard.

Dr. Sprince demonstrated a fortitude and stoicism during his years of illness rarely possessed by one so well acquainted with a disease which he knew could not be conquered. Despite this knowledge he brought health, solace and cheerfulness to many homes both in a professional capacity and as an inspiring friend—always attempting to bring to others a message of health and hope which he knew was denied to himself. His passing is an irreparable loss to the community which he enriched and served so well as a true physician.

County Note

Waldo

It is very gratifying to receive information that Carl H. Stevens, Councilor of the Fourth District, who was seriously injured in an automobile accident, is making an excellent recovery.

Coming Meetings

Maine Medical Association. Fall Clinical Session, Wednesday and Thursday, October 25-26, 1939, Waterville. Watch for the Program in your October JOURNAL.

Vermont State Medical Society. Annual Session at Burlington, October 5-6, 1939. Benjamin F. Cook, 154 Bellevue Avenue, Rutland, Vermont, Secretary.

Notices

Examinations

American Board of Obstetrics and Gynecology

The next written examination and review of case histories (Part I) for Group B candidates will be held in various cities of the United States and Canada on Saturday, January 6, 1940, at 2.00 P. M. *The Board announces that it will hold only one Group B, Part I, examination this year prior to the final general examination, instead of two as in former years.* Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held in June, 1940.

Applications for admission to Group B, Part I, examinations must be on file in the Secretary's office not later than October 4, 1939.

The general oral and pathological examinations (Part II) for all candidates (Groups A and B) will be conducted by the entire Board, meeting in Atlantic City, N. J., on June 8, 9, 10 and 11, 1940, immediately prior to the annual meeting of the American Medical Association in New York City.

Applications for admission to Group A, Part II, examinations must be on file in the Secretary's office not later than March 15, 1940.

After January 1, 1942, there will be only one classification of candidates, and all will be required to take the Part I examinations (written paper and case records) and the Part II examinations (pathological and oral).

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

Ragweed Survey, 1939

Two pollen receiving stations are being operated for the 1939 Ragweed Survey. One at Portland on the roof of the Maine General Hospital under the supervision of the hospital Superintendent and the other at Camden under the auspices of the Camden Chamber of Commerce. These stations which were opened August 10th will be continued for fifty days.

State of Maine Board of Registration of Medicine

Physicians licensed to practice medicine and surgery in Maine on July 12, 1939:

Through Examination

William Champlin Burrage, M. D., Portland, Maine.

Harry Edward Christensen, M. D., Portland, Maine.

Joseph Francis Dinan, M. D., Boston, Mass.

John Francis Dougherty, M. D., Bath, Maine.

Edward Thomas Driscoll, M. D., Worcester, Mass.

Lucio Ernest Gatto, M. D., Cambridge, Mass.

Harold Floyd Gilbert, M. D., Mt. Holly, N. J.

Napoleon Gingras, M. D., Augusta, Maine.

Marlin Charles Moore, M. D., Kulpmont, Penna.

Arthur Ames Nichols, M. D., Boston, Mass.

John Coleman Nunemaker, M. D., Boston, Mass.

Richard Rapp Owens, M. D., MacMahan Island, Maine.

Maurice Swain Philbrick, M. D., Skowhegan, Maine.

George Emil Ronne, M. D., Pawtucket, R. I.

Robert Borden Somerville, M. D., Bristol, N. B., Canada.

Douglass Willey Walker, M. D., Thomaston, Maine.

Lester Ray Whitaker, M. D., Portsmouth, N. H.

Russell Wigh, M. D., Boston, Mass.

Fredrick Francis Yonkman, M. D., Boston, Mass.

Through Reciprocity

Frederick S. Gray, M. D., Portsmouth, N. H.

Allen Harold Knapp, M. D., Calais, Maine.

Stanley Walter Machaj, M. D., Portsmouth, N. H.

James Calvin Martin, M. D., Baltimore, Md.

James Mitchell Parker, M. D., Chestnut Hill, Mass.

Arthur Gilson Pilch, M. D., Bloomfield, N. J.

George Capron Poore, M. D., Philadelphia, Pa.

Irvin Robert Schaen, M. D., Cincinnati, Ohio.

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*Tumor Clinics**

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 10.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital*—Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital—Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Book Reviews

"How to Play Golf"

By Ben Thompson, Yale Golf Coach. Published by Prentice-Hall, Inc., New York.

It has been feelingly said that golf is the only game that one pays to suffer. For quite some time certain players, ghost writers and other parrots of like ilk have filled the pages of golf magazines with articles on "instruction" that have resulted in confusion and worse. The end result of all this gibberish is that the average player tries the proposed nonsense, finds his troubles even worse, reverts back to his own particular ideas or those of his friends of what a golf swing should be and confidingly but dumbly hopes for the best. His medal scores mount with an increasing sense of irritation and defeat and he strives to find solace and peace on the "19th" with his fellow sufferers.

The author speaks from years of experience as a teacher and player. It is extremely refreshing to read such a sane and sensible book of instruction, free from silly and nonsensical theories, and the player who will read and study the advice given, be he one of skill or desiring it, will obtain much of profit and pleasure. Thompson states in his preface: "Golf is a pleasant game if the player accomplishes pretty much what he aims at; it is usually a source of vexation and profanity if it fails. To make the game pleasant and easy—as a matter of fact it is—is the goal of instruction, and to that end this book is dedicated."

The book is heartily recommended to those who would find a way out of their difficulties resulting from the mistaken ideas of the few basic fundamentals around which a successful and enjoyable game is made.

F. H. J.

"New and Non-official Remedies"

Published by The American Medical Association, Chicago, 1939. Price, $1.50.

"Annual Reprint of the Reports of the Council on Pharmacy and Chemistry of the American Medical Association for 1938"

Published by The American Medical Association, Chicago, 1939.

This year's revision presents a number of changes. Several preparations previously listed have been omitted by reason of non-conformity to certain standard requirements. Many others have been removed because they were taken out of the market. Many articles describing preparations previously listed have been revised to conform with present-day perfection of their composition, purity, strength, action, uses, and dosage. The present issue comprises five hundred thirty-one pages of text, eighty-three pages of general index and sixty-seven pages of bibliographic index.

The annual reprint of the reports are contained in a small book of one hundred twenty pages. This booklet was published in order to make these reports available to physicians, chemists, pharmacologists, and any others who may be interested in medicine and the Council's report on the articles considered.

"Superfluous Hair and Its Removal"

By A. F. Niemoeller, A. B., M. A., B. S., Author of "Feminine Hygiene in Marriage," etc. Foreword by M. H. Marston, M. D. Published by the Harvest House, New York, 1938. Price $2.00.

Concerning hair removers, the author writes: "In order to guard the reader against fraudulent advertising and the golden promises of quacks, it may be well here to state clearly and definitely that regardless of what claims may be made by the manufacturers or by whom their products are said to be endorsed, there is *no* known drug, paste, lotion or application of any sort that may be applied to the skin and effect a permanent removal of hair there." Now this statement left to itself could not fill a book. However, the author did write this hundred and fifty page book while telling the reader how men and women of past and present ages take care of hair which they consider superfluous. It seems that the human mind has been able to discover that hair growing anywhere on the human body above the soles of the feet can and has been considered superfluous and then this same human mind devised means and methods for removing hair thus designated, and rationalizes the habit of doing so.

"In the Name of Common Sense Worry and Its Control"

By Matthew N. Chappell, Ph. D. Published by The Macmillan Company, New York, 1938. Price, $1.75.

This small volume of 188 pages seems to have caught the reader's eyes. Published in March, 1938, it had to be reprinted six times before the end of the year in order to supply the demand. The book is written for and about normal people and offers nothing to those interested in the psychoses.

The author tells his readers that "worry is a luxury—one that neither the individual nor the civilization can afford. A more expensive luxury would be difficult to imagine. The cost to the individual is to be reckoned in terms of illness; bills for doctors, nurses, hospitals, and medicines; in loss of wages and opportunities, and inefficiency; in terms of mental agitation, irritability, family discord, undesirable personality traits, and adverse influence on friends, family and children." The reader is placed before his worries as if they represented a mirror reflecting qualities which are of negative value in the individual's life for success. He is encouraged to laugh off his foolish fears and practice sanely controlled emotional activity.

"Syphilis and Its Accomplices in Mischief: Society, the State and the Physician"

By George M. Katsainos, M. D.

Privately printed at Athens, Greece, 1939. Price, $5.00.

It is very evident that the author of this book experienced almost insurmountable difficulties of many kinds from inception to completion of his present work. The book is rather unusual in many ways. It consists of 675 pages; these are neither bound nor cut. Apparently it was conceived in

New England, composed and printed in Athens, Greece, by a man who is said to be able to set type in every European language but knows no English, and to be sold to the English-reading world. The original plan was that about one-fifth of the text should appear in the form of footnotes, but the present edition is printed in uniform type; that is to say, the footnote information is incorporated in the main text. There is no index and no bibliography, even though the text teems with quotations from many authors of ancient Greece, European and American medical and lay literature, ranging from the fifteenth to the present century. To all appearances, the author is a fine Greek scholar, deeply rooted in early Greek tradition and spirit, and is well versed in the Greek language.

The book is written in the conviction that its author possesses a wealth of truthful knowledge concerning syphilis and all its many intertwining, complicating ramifications, including the various modifications of the human element constantly expressed during the many and varied patient-physician relationships which may be encountered by any practitioner while working with syphilis as a disease as such, as a specific infection of a certain kind of a person, or as a particular form of regime in individual-family-society behavior. To be able to conceive of the possibility to verbally clarify such a complicated conglomeration of situations and to dare hope to be able to devise methods by which the problems resulting from all possible conflicts can be solved to the satisfaction of all concerned, presupposes a clear, mature mind, a wide range of knowledge, much spiritual ambition and courage, physical endurance, and above all, almost superhuman wisdom. It seems almost inconceivable that somewhere there lives now one man who possesses all of these attributes. In order to fulfill his mission, "To clear syphilis of its asyphilon," the author must possess all of them and many more. One may honor and respect all the excellent qualifications which Dr. Katsainos may possess as a man, a scholar, and as a physician, but careful study of the book under review gives the impression that he attempted too much alone.

"The Patient as a Person—A Study of the Social Aspects of Illness"

By G. Canby Robinson, M. D., LL. D., Sc. D., Lecturer in Medicine, Johns Hopkins University.

Published by The Commonwealth Fund, 41 East Fifty-seventh Street, New York, N. Y., 1939. Price, $3.00.

Quite contrary to some of the modern ideologies, every human being differs from every other human being in an indefinite number of ways. Some of the most demonstrable differential characteristics have their bases in sex, race, age, constitutional, personal and familial make-up primarily due to inheritance, secondarily to early environment, childhood experiences, education, economic variations and many other factors. Somewhere within this singularly occurring composition of a human being lie dormant the causes for his feeling of well being and of ill health. Because of this singularly occurring make-up, medical art must devise methods for reaching and adequately serving the individual while medical science discovers and invents mechanical systems and appliances by which similar reaction responses to similar stimuli may be investigated in a definite number of similarly constituted but individually differently-reacting individuals. This dissimilar similarity which always exists in the person investigated, the patient, as well as in the person investigating, the doctor, must be better understood by both for best results. No doctor can afford to disregard this basic truth. Consequently, the whole of man, alone as a self-contained unit as well as a changing unit in a changing environment, must be included in his medico-scientific investigation as well as in the practice of his medical art for the purpose of reëstablishing this human unit in an environment most appropriate to his needs after he had lost his hold while placed in a situation of maladjustment by disease, accident, or other uncontrollable alterations in himself or his environment. To determine the elements which often enter into the illness of the patients under investigation was the purpose of the study carried out in 1936-37 in the Johns Hopkins Hospital. The results are presented in the form of detailed case reports and comprise a total of 174 patients, studied intimately in all phases for a period of six months. In the reports here presented, no patients have been omitted, because it was deemed highly desirable to give the complete picture of each case.

"Surgery of the Eye"

By Meyer Wiener, M. D., Professor of Clinical Ophthalmology, Washington University School of Medicine, St. Louis, Mo.; and Bennett Y. Alvis, M. D., Assistant Professor of Clinical Ophthalmology, Washington University School of Medicine, St. Louis, Mo.

Published by W. B. Saunders Company, Philadelphia, London, 1939. Price, $8.50.

The volume under review represents an atlas of surgical technique for the eye surgeon. It is dedicated to that master eye surgeon, Dr. Charles E. Michel. The authors did not attempt to create a reference work. They present in detail that type of operative technique which they found most ideally applicable to the condition under treatment. The descriptions of the operations are excellently illustrated with masterful drawings executed by Dr. A. J. Hofsommer, thus assuring anatomically and technically correct pictorization of the steps involved. Surgeons specializing in the art of reconstructing the form and function of the eye will be pleased with this new addition to medical literature.

"Heart Patients—Their Study and Care"

By S. Calvin Smith, M. D., Sc. D. Formerly special heart examiner for the Surgeon General's Office during the World War at Home and Abroad; author of "Heart Affections: Their Recognition and Treatment"; "Heart Records: Their Interpretation and Preparation"; "How Is Your Heart?" (New York and London); "That Heart of Yours."

Published by Lea & Febiger, Philadelphia, 1939. Price, $2.00.

It seems that of the several small books that have been written in the past on the care of the heart, this is the best of them all. During about twenty-five years of specialization on patients with heart troubles, Dr. Smith has brought together into this pocket-sized volume a great wealth of practicable wisdom applicable in every day's medical practice. The author's long experience taught him the simple truth: "The heart is far more

sinned against than sinning." In readily understandable language, he describes directly, concisely and constructively what is known about heart affections and what must be known about the modern trend in dealing with persons suffering from some form of abnormal heart function. Again and again he reminds the reader that it is often more important to learn more of the patient that complains of heart trouble than to concentrate on the particular heart that tries to serve well a person in conflict with his everyday way of living. He considers the heart as a barometer of the emotions; consequently, the understanding physician must try to ease the patient whose heart is burdened with fears, worries, anxieties, etc. It, therefore, is the duty of every doctor to detect, assuage, and if possible eradicate the emotional conflict often concealed by heart patients' complaints. Not to have read Dr. Smith's "Heart Patients" is like traveling alone abroad without an old friend's wise counsel.

"Diseases of the Nose and Throat"

By Charles J. Imperatori, M. D., F. A. C. S. Professor of Otolaryngology, New York Polyclinic Medical School and Hospital; Formerly Professor of Clinical Otolaryngology, New York Post-Graduate Medical School, Columbia University, New York; Consulting Laryngologist to Nyack General Hospital and Harlem Hospital, New York; Consulting Bronchoscopist to Manhattan Eye, Ear and Throat Hospital, Fifth Avenue, and Flower Hospital and Riker's Island Hospital, New York; and Herman J. Burman, M. D., F. A. C. S. Adjunct Professor of Otolaryngology, New York Polyclinic Medical School and Hospital; Formerly Assistant Professor of Clinical Otolaryngology, New York Post-Graduate Medical School, Columbia University, New York; Director of the Department of Otolaryngology, Harlem Hospital, New York; Consulting Bronchoscopist to Broad Street Hospital and Pan-American Clinics, New York.

Published by the J. B. Lippincott Co., Philadelphia, 1939. Price, $7.00.

The material in this text is so arranged that the senior medical student and the general practitioner progresses systematically from the patient as a person through the symptoms which he presents to the diagnosis and the treatment of his pathologically functioning body. This form of presentation was carried over from the first into the body of this, the second edition, but there have occurred a great many changes and additions which were necessitated by the rapid progress in this field. The description of office procedure and therapeutic technic is usually given in full detail in order to insure greater success in the attainment of best results. The technical and the anatomical illustrations are excellent. Some of the pathological reproductions, however, would certainly gain in attractiveness if those with unsightly oval ocular blotches, like Fig. 49, 52 and 218, were replaced with square or rectangular masks similar to those on Page 102 (Fig. 68 to 73) if such obliterations are necessary or requested. This is an excellent textbook but good, inoffensive illustrations always make a good book better.

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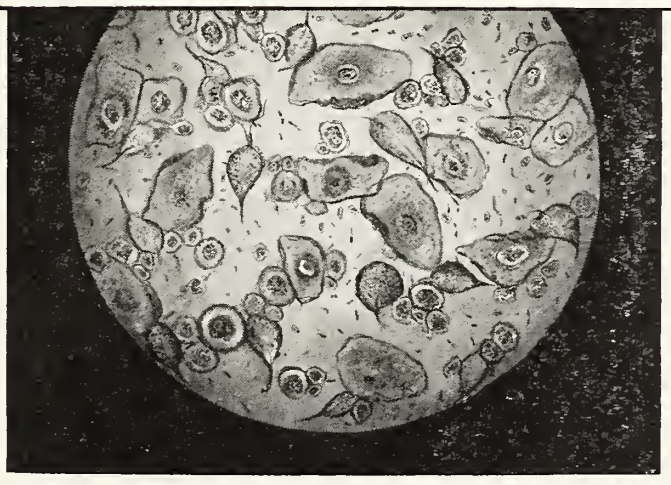

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Dr. Wiggin—Continued from page 221

Conclusion

Traumatic surgical cases are different from general surgical patients because they present such a variety of complications necessitating emergency treatment, which deserve special attention in anesthesia by experienced physicians. The proper choice of premedicating drugs, anesthetics and the methods of administration are of great importance to the safety and comfort of the patient, allowing for rapid and complete operation by the unhampered surgeon. The recognition and proper treatment of complications in these cases is imperative.

Dr. Pratt—Continued from page 223

formed under local anaesthesia. No difficulties were encountered and the boy made an uneventful recovery in spite of having had a laryngeal diphtheria for over two weeks.

This case illustrates a practice all too common and one that cannot too strongly be condemned, namely, prescribing for hoarseness without ascertaining the cause of the hoarseness. It is an extremely common practice in dealing with children and by no means uncommon in adults. It is responsible for countless number of deaths either from toxemia or advanced carcinoma. No case of hoarseness should be treated without first obtaining a good look at the larynx, any more than an earache should be treated without looking at the eardrum.

In children suffering from severe dyspnoea the use of the bronchoscope should be routine in all cases where a tracheotomy is to be performed. It immediately establishes an adequate airway; it relieves intrathoracic pressure; it converts a frightened, struggling child into a quiet one who has lost his apprehension; it converts a hurried operation into an orderly one; the tube in the trachea serves as a guide to the surgeon.

(1) The Larynx and its Diseases; Chevalier Jackson and Chevalier L. Jackson. Page 459.
(2) *Ibid.* Page 455.
(3) *Ibid.* Page 459.

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PROCEEDINGS

at the

EIGHTY-SEVENTH ANNUAL SESSION

of the

MAINE MEDICAL ASSOCIATION

held at

THE POLAND SPRING HOUSE

POLAND SPRING, MAINE

JUNE 25, 26, 27, 1939

HOUSE OF DELEGATES

ELECTION OF THE PRESIDENT-ELECT

FIRST MEETING OF THE HOUSE OF DELEGATES, JUNE 25, 1939

The Opening Session of the House of Delegates of the Maine Medical Association convened on Sunday, June 25, 1939, at four-fifty in the afternoon, at the Poland Spring House, Poland Spring, Maine, with Dr. George L. Pratt, of Farmington, President-Elect of the Maine Medical Association, presiding.

CHAIRMAN PRATT: The meeting will please come to order. The Secretary will now call the roll.

(The Secretary called the roll and the following delegates responded):

Androscoggin County: W. E. Webber, Lewiston.

Aroostook County: H. E. Small, Fort Fairfield.

Cumberland County: L. A. Brown, W. D. Anderson, Ralph A. Heifetz, D. H. Daniels, Portland; J. C. Oram, South Portland.

Franklin County: C. C. Weymouth, Farmington.

Hancock County: M. A. Torrey, Ellsworth.

Kennebec County: Samuel H. Kagan, Augusta; Charles E. Towne and Howard F. Hill, Waterville.

Knox County: Howard Apollonio, Camden; A. J. Fuller, Pemaquid.

Oxford County: E. M. McCarty, Rumford.

Penobscot County: L. J. Wright, Henry C. Knowlton, Forrest B. Ames, Bangor; L. H. Smith, Winterport, Alternate.

Sagadahoc County: A. F. Williams, Togus.

Somerset County: W. H. Walters, Fairfield.

Waldo County: Carl H. Stevens, Belfast, Alternate.

York County: S. A. Cobb, Sanford; C. W. Kinghorn, Kittery.

CHAIRMAN PRATT: We have a sufficient number for a quorum. I would say that the Councilors are also members of the House of Delegates. I hope you will pardon my short-comings as a presiding officer as I am not a parliamentary expert, but I will agree to carry on.

There is one thing I would like to say at the start. We frequently, or sometimes at least, find after things get into print that it is something incorrect or something we didn't want to get out. I would, therefore, ask all reporters, or anyone who has anything to print, to kindly submit the matter to our Publicity Committee first. Dr. Thomas Foster is the Chairman of that Committee and on that point Dr. Jackson would like to say just a word on behalf of the JOURNAL.

DR. FRANK H. JACKSON, Houlton, Editor *The Journal of the Maine Medical Association:* Last year, as you know, we published in full the transactions of the House of Delegates. The general request is that every member who addresses this House, as long as this is a permanent record, will please give his name and address before he speaks, because we are going to be obliged to delete any and all matters that come up in which it simply states, as it did last year several times, "A Doctor."

Now, please remember that what goes on in the House of Delegates is important to this Association. You, and you alone, can make certain pronouncements, and you have laid down certain things that we must follow. It is very interesting, and it is also important, that the members who are unable to attend these sessions know what you do and what you say. A great deal of this matter leaks into the public press and also leaks, sometimes, into hands that are hostile to us.

Therefore, please give us the benefit of knowing who is speaking. If there is anything that we think should be omitted in publishing or printing, we will take care of that part of the situation, but your remarks as spoken stand here, and they are a matter of record in the JOURNAL of the Society.

CHAIRMAN PRATT: I will appoint the Reference Committee to consider a resolution which may be referred to them: Dr. Ebbett, of Houlton, Chairman, Dr. Wallace E. Webber, of Lewiston, Dr. Kinghorn, of Kittery.

I also appoint the following Nominating Committee, consisting of one delegate from each Councilor District: from the Fifth District, Dr. R. V. N. Bliss of Bluehill, Chairman; from the First District, J. C. Oram, South Portland; from the Second District, E. M. McCarty, Rumford; from the Third District, Howard Apollonio, Camden; from the Fourth District, Samuel H. Kagan of Augusta; from the Sixth District, Forrest B. Ames, Bangor. I will say that this committee will meet in the hall with the Chairman and be ready to present your nominations at the second meeting of the House tomorrow afternoon at 5.30. I would also like to ask the delegates from the First and Second Districts to meet and be ready to present their nominations for Councilor in each one of these Districts at the same time.

The next article of business will be the report of the Council, to be made by the Chairman, Dr. Foster.

DR. THOMAS A. FOSTER, Portland, Councilor from the First District, Chairman of Council: Mr. President and Delegates: (Dr. Foster read the following reports: First meeting of the Council for 1938-1939 held at Bar Harbor, June 28, 1938; second meeting held at Searsport, July 31, 1938; the financial statement of the Eighty-Sixth Annual meeting of the Maine Medical Association, held at Bar Harbor, June, 1938; third meeting of the Council held at Waterville, September 11, 1938; fourth meeting held at Lewiston, November 3, 1938, at 12 o'clock noon; fifth meeting held at Lewiston, November 3, 1938, at 5.30 p. m.; and sixth meeting held at Lewiston, November 3, 1938, at 10.30 p. m.).

DR. FOSTER: There are the six meetings reported, and I have in addition Council business transacted by mail. (Dr. Foster read report of Council business transacted by mail.)

DR. FOSTER: That concludes the report of the Council.

CHAIRMAN PRATT: You have heard the report of the Chairman of the Council. What action will you take?

A MEMBER: I move it be accepted.

This motion was duly seconded and carried.

CHAIRMAN PRATT: The next article of business is the presentation of the 1939-1940 budget as recommended by the Council, and will be presented by Dr. Foster.

DR. FOSTER: This isn't going to be as long, so don't get wearied. (Dr. Foster read the budget as recommended by the Council.)

BUDGET, 1939-1940

President's Expenses	$ 300.00
Salaries	
Secretary-Treasurer	1,200.00
Assistant Secretary	1,500.00
Office Expenses	
Secretary-Treasurer	300.00
Portland Office	600.00
Committees	
Medical Advisory	500.00
Graduate Education	500.00
Other Committees	300.00
State Delegates and Council	200.00

Delegate, A. M. A. Annual Session	250.00
Annual Session	200.00
Clinical Session	200.00
Appropriation to Journal ($2,000.00)	
Editor's Salary	1,000.00
Journal Expenses	1,000.00
Total	$8,050.00

Dr. Foster: I have the figures for last year, and if there are any questions these figures can be read. The total—excuse me, Mr. Chairman, but the total is Eight Thousand Fifty Dollars.

Chairman Pratt: You have heard the report of the Chairman of Council on the budget. What action will you take on that?

Dr. Samuel H. Kagan, Augusta: Mr. Chairman, do I understand that this is the budget for 1939-40?

Chairman Pratt: Yes.

Dr. Kagan: You stated 1938-39.

Chairman Pratt: If I stated it, I am wrong.

Dr. Foster: If I stated it, I am likewise wrong.

Dr. Wallace E. Webber, Lewiston: Mr. Chairman, from the budget there, do I understand the Journal expenses are approximately Four Thousand Dollars? It is in four items, isn't it, or three items?

Dr. Foster: The Council recommends that the Journal have Two Thousand Dollars.

Dr. Webber: Yes, but were there two other items?

Dr. Foster: The Editor has One Thousand and the Journal itself has a thousand.

Dr. Webber: That makes—

Dr. Foster: Sorry I misled you. The Editor's salary is one thousand and the Journal one thousand. The thousand dollars is to cover any deficit. The thousand dollars is property.

Dr. Webber: Might I ask what the income is expected to be for the year?

Dr. Foster: From the Journal?

Dr. Webber: No, not the Journal; the Society's income.

Chairman Pratt: It is printed in the Journal on the last page.

Dr. Frederick R. Carter, Augusta, Secretary-Treasurer of the Maine Medical Association: It is in the Auditor's report.

Dr. Webber: I ought to have known it, then, after reading it.

Chairman Pratt: I might say that the total expenditure is $9,992.59. I might say we came out somewhat ahead this year in finances. I couldn't remember exactly. If anybody is interested to know, we will call on the Treasurer.

Dr. Kagan: Mr. President, I would like a little elucidation for the appropriation of $500 for your graduate study. What does that usually go to?

Chairman Pratt: Dr. Foster will explain.

Dr. Foster: As Chairman of the Council, I can report to you the discussion held at the Council meeting. The Committee thought they might need $500 last year to carry out their program which we understood was to have speakers come to Maine in various parts of the state, most likely in the rural communities, and give courses in medicine of one kind or another. It was thought that $500 would cover all those expenses. As it happened, the program was not inaugurated and that money was not spent. But the plan of the Committee has been to have some medical education by young men and pay the expenses of the men who give the post graduate medical education out of that $500.

A Member: Can you give us any information of the cost for last year of that same thing?

Dr. Foster: The Committee on Medical Education spent $55.80. It was appropriated at their request because they had formulated the policy of having some speakers or teachers come into the state and give some lectures or give some courses; but it didn't get going in time to carry it out.

Dr. Kagan: Might I ask as to what happened to the difference between the $55.00 and the $500 that was appropriated? Did that go back to the treasury?

Dr. Foster: No, that is still in the treasury. It never went out.

Dr. Henry C. Knowlton, Bangor, Member Legislative Committee: Mr. Chairman, may I move the Council budget be accepted by the House of Delegates.

This motion was duly seconded by several of the members present and was carried.

Dr. Jackson: Mr. Chairman, I am not a member of the House of Delegates, but I would simply like to answer one or two questions that have been asked, in the absence of Dr. Hill, Chairman of the Graduate Committee. That $500 was appropriated to be used as we saw fit, if and when the Secretaries of the County Societies asked us to furnish speakers, as they wished them. The plans of the Committee, unfortunately, were in a formulative state and we began to develop discussions and as yet we did not import very many men.

There were a few men came in who came through the County Societies, and their expenses were taken care of. The Committee is able to report the very small amount that is expended simply from the fact that a great many of the men in the state assumed their own expenses for a great many things, and a great many things were done in the Journal office; that is, printing of the various personal discussions and things for which the Society didn't have to pay anything out of that money.

But we do feel that $500 is the minimum amount which we would like to have at our disposal so that during the coming winter we can, at the request of the various County Societies, furnish them with speakers well known and well versed in their subjects, on special subjects. That is the idea of having that money at our disposal.

Chairman Pratt: Thank you, Dr. Jackson. This plan simply hasn't gone into operation yet. It is still in formation.

Dr. Jackson: No, it is still in the formulative state. We have some very valuable programs in progress, we have some very valuable, helpful men. Dr. Hill will be here by and by; Dr. Gottlieb is here now; probably Dr. Nickerson will be here, and we will have a committee meeting and perhaps at the next session of the House of Delegates we can give you something fairly definite that we will lay out for the individual members and for the Society through its County organizations as a unit during the coming year.

Chairman Pratt: The next article of business is the report of our delegate to the American Medical Association, Dr. Ellingwood.

Dr. William A. Ellingwood, Rockland, Delegate to the American Medical Association: Mr. Chairman and members of the House of Delegates: The ninetieth annual session of the American Medical Association was held in St. Louis, Missouri, May 15 to 19, 1939, with headquarters located at the Statler Hotel.

(Dr. Ellingwood then read his report of that meeting.)*

* Published in the July, 1939, issue of the Journal, page 177.

Chairman Pratt: You have heard the report of our delegate to the American Medical Association. What action will you take?

A Member: I move it be accepted.

This motion was duly seconded and carried.

Chairman Pratt: The next business is the report of the delegates to our neighboring New England States. I may say that I had the pleasure of being the delegate to New Hampshire, and I had a very enjoyable time. They met in Manchester, where they hold their meetings every year. They had their one hundred and forty-eighth annual meeting, which makes them 61 years older than we are. They conduct their meetings in a good deal the same manner as we do. They have conferences, and the papers in the afternoon.

I was much interested in one resolution passed by their House of Delegates, which I won't read, but it condemned the Wagner Act, with which I agree most heartily. I had the pleasure of hearing Dr. Rock Sleyster, President of the American Medical Association. He talked on the Wagner Health Act and it was a magnificent edit. I wish we had him with us. I expect Dr. Fishbein will do as well. I had a very nice time.

The delegate to Massachusetts, Carl M. Robinson. Is Dr. Robinson present? (No answer.)

The delegate to Rhode Island, Dr. Campbell, will report tomorrow.

The delegate to Connecticut, Dr. Eugene O'Donnell, Portland. Is Dr. O'Donnell present? (No answer.)

The delegate to Vermont, Foster C. Small of Belfast; he is not here, either. We will have to have these reports later.

The next article of business is the report of the Standing Committees, which are not published in the Journal. Those that are published, it isn't necessary that they be given here. The report of the Public Relations Committee, George R. Campbell, M. D., of Augusta; he is not here today.

Committee on Social Hygiene, E. S. Merrill of Bangor. Is Dr. Merrill present? (No answer.)

Committee on Nursing Affairs, by Dr. Bryant. Dr. Bryant, I understand, is sick and is unable to be here.

Tuberculosis Committee, George E. Young of Skowhegan. He is not here.

Committee on Investigation of Collection Agencies, Dr. Gehring, Portland, reports there have been no inquiries this year, therefore there is no report.

Committee on Problems of Health Insurance and State Medicine, Dr. Kershner, from Bath. Dr. Kershner remarked—I guess I will let him tell about it himself.

Dr. W. E. Kershner, Bath, Chairman Committee on Problems of Health Insurance and State Medicine: Go ahead, you do the talking.

Chairman Pratt: I was going to say I thought Dr. Kershner last year remarked that this committee should be combined with the Graduate Education Committee, and if I remember right no action was taken. I think we will call on Dr. Kershner just the same.

Dr. Kershner: Mr. Chairman, the committee appointed met within two or three weeks after the Annual Meeting and decided that in view of the fact that we had completed the work that we were originally appointed for, and in view of the fact that there were still uncertainties existing abroad, that we sit tight for the time being.

The Chairman of the Committee did report to the Secretary of the American Medical Association that we had conducted a survey and then stated or reported the elements of that survey to him, for which he received the thanks of the central office. There is nothing further.

Chairman Pratt: Thank you, Dr. Kershner. For the Committee of Representatives of Appointed Hospital Staffs, M. C. Moulton, of Bangor, will report. Is Dr. Moulton here? (No answer.) I don't know what other members were on that committee. If there are any we might hear from them. (No answer.)

Committee on Maternal Welfare, Roland B. Moore of Portland. Dr. Moore is not here.

Dr. Ellingwood has a matter that he would like to bring up at this time.

Dr. Ellingwood: Mr. Chairman and members: In connection with this Committee on Maternal Welfare, we have with us today Dr. Weaver who is here in connection with the American Committee on Maternal Welfare, Incorporated, consisting of representatives of several well-known institutions, and I think we would like to listen to Dr. Weaver just a few minutes. It is a pleasure for me to present to you, Dr. Weaver of Philadelphia.

Dr. Ruth Hartley Weaver, Philadelphia, Pa., representing the American Committee on Maternal Welfare, Inc.: Mr. Chairman, I will just take a few minutes of your time because tomorrow you will see the motion pictures of "The Birth of a Baby" which were produced under the auspices of the American Committee on Maternal Welfare.

I have prepared a map here which shows the states marked in yellow where the picture is now being shown. Besides that there are eleven other states offered where the picture has been approved by the State Medical Society. It was a ruling of the American Committee on Maternal Welfare that it should be shown nowhere before it was approved by the State Medical Society, and I believe this is the first opportunity that Maine has had to vote on whether the picture shall be shown in the general motion picture houses throughout Maine.

As you know, there is a great deal of value in visual education, and there are a great many maternal deaths unnecessary. General surveys have shown at least half, and in some places two-thirds, of the maternal deaths could be prevented; and of those preventable deaths, about half are attributable to the mother. And it is usually through her ignorance in not knowing what good maternal care is, which causes her death.

Now this picture was produced primarily to reduce unnecessary maternal deaths. Of course infant deaths in the early stages are closely associated with maternal care. This picture does just that thing. It shows what the mother should expect in maternal care. It is just a medical sound picture, which could give offense to no one. It has been approved by all types of organizations, and I would like to have you view it tomorrow and vote on it when you do take up the matter, considering that it can save some lives of mothers.

Now in Maine the maternal death rate is not enviable. I think you have some forms here which show the death rate in Maine since 1915. You will notice that it isn't one of the best states, because the last official rate that I have is 6.6 per thousand live births. So you see there is still much work to be done in Maine in regard to maternal mortality.

Now there are certain restrictions which this Committee on Maternal Welfare place around the picture. In the first place, it is a feature picture. No other featured film can be shown, and the short films must be approved by the American Commit-

tee on Maternal Welfare. There should be no commercial hook-up, no advertising that is not approved. The general price of the theatre shall not be raised when this picture is shown. So there is no reason why it cannot be produced carefully and under good auspices throughout the state of Maine. I thank you.

Chairman Pratt: As I understand it, Dr. Weaver, you would like to have the approval of the House of Delegates?

Dr. Weaver: I would.

Chairman Pratt: For showing tomorrow afternoon?

Dr. Weaver: No, to be shown throughout the state.

Chairman Pratt: To be shown throughout the state?

Dr. Weaver: Yes.

Chairman Pratt: It will be shown here tomorrow afternoon anyway?

Dr. Weaver: At five o'clock, or five-thirty.

Chairman Pratt: You see, this American Committee on Maternal Welfare consists of representatives of the American Association of Obstetricians, Gynecologists, and Abdominal Surgeons, American College of Surgeons, American Gynecological Society, American Hospital Association, American Protestant Hospital Association, Section on Obstetrics and Gynecology of the American Medical Association, American Nurses' Association, American Public Health Association, Catholic Hospital Association, and a lot more. Does anyone wish to make a motion in regard to this?

Dr. C. W. Kinghorn, Kittery, Secretary York County Society: Mr. President, it being the fact that this is approved in practically every state in the Union with a few exceptions, I make a motion that this Association go on record as approving the picture.

A Member: Mr. President: I rather feel that before we approve it, we should see it; I don't think we should approve things too blindly. The picture is here and it is a question of one day when we can see it, and I think it would be much more advisable to have the delegates view it and know what they are talking about.

Dr. Kinghorn: I have seen it.

A Member: I haven't.

Dr. Carl H. Stevens, Belfast, Councilor Fourth District: Last fall I saw this film at the American Surgeons' Meeting in Chicago. It was presented late one afternoon and the following evening in the theatre, so the members of the College might approve or disapprove whether it should be shown publicly. If a time could be arranged, I think that might meet with the approval of the delegates.

Chairman Pratt: Dr. Kinghorn's motion is before the house. I haven't heard it seconded.

Dr. Kinghorn: The time this picture is going to be shown is during the meeting, and we will have opportunity to see the picture.

Dr. Weaver: May I suggest that Dr. Moore was here this morning and he requested that it be shown about 11.30 tomorrow morning if that were possible, because that would be at the end of the morning session and then the luncheon meeting after that could be arranged.

Chairman Pratt: How long does it take?

Dr. Weaver: Seventy minutes.

Chairman Pratt: Is Dr. Cobb here?

Dr. Stephen A. Cobb, Sanford, Chairman Scientific Committee: I don't think it is a good time to show it, that is all. It fits in with the program the best tomorrow night after the Scientific session. Of course the House of Delegates can see part of it before they go into session. I don't know any reason why they shouldn't vote on it at that time. Tomorrow noon we have the meeting of reunion classes and they come at the noon hour, and there are a lot of fellows in the golf tournament and we do want to get all the ladies present possible to see this. I would rather see it shown tomorrow night at five o'clock, if possible. And I don't see any reason why we couldn't approve or disapprove of this picture. There is only one state in the Union that has disapproved of it for public showing.

Dr. W. N. Miner, Calais, member Legislative Committee: Mr. President, is there any reason why this picture couldn't be shown tonight for us?

Dr. Cobb: The only reason is that this is a sound picture and they have to have the operators out from Portland to put it on. It is brought out here at expense of the Association, and it will have to be put on tomorrow on its schedule at five o'clock tomorrow night. I might be able to put it on at eleven-thirty tomorrow, but it doesn't fit in with the program.

A Member: Mr. Chairman: My point of view is, Dr. Kinghorn and Dr. Stevens have both seen it and both think it should be shown; I would be in favor of moving that it be shown publicly.

Chairman Pratt: Do you wish to second Dr. Kinghorn's motion?

Member: Yes.

Dr. Foster: Mr. Chairman, in adding my testimony to Dr. Kinghorn's and Dr. Stevens', it was shown at the N. E. Pediatric Society meeting at the Copley Plaza Hotel in Boston and it was approved by them. That is simply more testimony in its favor.

Chairman Pratt: All those in support of Dr. Kinghorn's motion that the picture may be shown publicly in Maine, please raise their right hand. Those opposed?

Chairman Pratt: Upon a hand-raising vote, the motion was carried.

I think that Dr. Wallace Webber has a matter he would like to bring before the House.

Dr. Webber: Mr. Chairman and members: The Androscoggin Society held a meeting of the association this winter and instructed every delegate to report to the delegates here in regard to two things. The first one is in regard to the telephone company charging business rate to the physician having an office in his home. Possibly all of you noticed that the New York physicians carried on quite a battle and finally won out, that they should pay a minimum house rate instead of a business rate in instances where they had an office in their home.

On investigation I think we found that the New York Public Utilities Commission had ruled in their favor, and our Public Utilities Commission have made no similar ruling. I don't know just exactly what action would be called for in that, but it seems to me that it is one that would be investigated carefully before any definite action would be taken; and in that particular thing I would move that the Secretary of our Association investigate the possibilities of reducing the telephone rate to physicians having their offices in their homes. I would make that as a motion.*

* Editorial Note: From this decision an appeal has been taken and a new trial has been granted and it is said that if the ruling is upheld by the higher court more than $2,000,000.00 will have to be refunded to physicians in the territory involved.

Dr. W. H. Walters, Fairfield, President Somerset County Society: I wish to second that motion.

Dr. Webber: Of course if it is seconded it would be law.

Chairman Pratt: Who seconded it?

Dr. Walters: Dr. Walters.

Chairman Pratt: Dr. Walters of Fairfield seconds the motion. Will you make that motion in writing, Doctor?

Dr. Webber: The motion is that the Secretary investigate the possibilities of the telephone company's reducing the telephone fee of physicians having their office in their home, from a business rate to a house rate or home rate.

Chairman Pratt: The motion is made and seconded. Is there any discussion?

Dr. J. C. Oram, South Portland: Mr. President, if I may say a word, before we go to the Public Utilities Commission with that, may I offer as an amendment before the committee meets with the Public Utilities, that the Committee get in conference with the officials of the telephone company. I understand that they are not particularly anxious to have that come before the Utilities Commission, and you may be able to do business without too much involvement. So that as an amendment I offer this: before the committee meet with the Public Utilities Commission in regard to telephone rates of doctors having offices in their homes, that the committee first get in touch with the officials of the telephone company to find out their particular attitude in the matter. If they are unfavorable to such a request, then I suggest that the committee be empowered to take up the matter with the Public Utilities Commission of Maine.

Chairman Pratt: You have heard Dr. Oram's amendment.

Dr. Webber: He made that as an amendment to the motion?

Chairman Pratt: He made that as an amendment to the motion. Do you accept that amendment to your motion, Dr. Webber?

Dr. Webber: I accept it, yes.

Chairman Pratt: Dr. Webber accepts the amendment. You have heard Dr. Webber's motion as amended by Dr. Oram. Is there any further discussion? Do you accept the amendment, too, Doctor Walters?

Dr. Walters: I accept it.

Chairman Pratt: All in favor of Dr. Webber's motion as amended by Dr. Oram, please raise your hands.

Upon a hand vote the motion was carried.

Dr. Webber: The other matter also had reference to the telephone. In our telephone directories the habit of the telephone companies is to put us down as doctors, which they do to the osteopath, the chiropractor, and various other people who have a "doctor" attached to them, and they do not put down the "M. D."

It was moved by the Androscoggin County Medical Society that it was their desire that their names be booked in the telephone directories as M. D.'s, not merely as "Dr.", but as M. D.'s. That seems to me a reasonable request.

I would move that if it is the mind of the delegates here, our names be posted in the telephone directories with the appendix "M. D." after them.

Dr. Kagan: I think in other counties we are listed as "physicians," and the others as "osteopathic physicians" or "chiropractic physicians." I think it is a local thing; I think you could straighten that out.

Dr. Webber: It is local?

Dr. Kagan: I think so.

Dr. Webber: Then it shouldn't be of any importance if it is local.

Dr. Kagan: I think you could straighten it out, Dr. Webber, at home.

Chairman Pratt: You have heard Dr. Webber's motion; is the motion seconded?

A Member: I second the motion.

Dr. Kagan: I think Dr. Webber wants to withdraw his motion in view of the information given.

Dr. Webber: If it is local.

Dr. Kagan: I think it is local. In Augusta we are listed as "physicians" and "osteopathic physicians."

Dr. Webber: If it is local in Androscoggin County—I don't think we knew it was local.

Chairman Pratt: Do you wish to withdraw the motion?

Dr. Webber: I withdraw the motion.

Chairman Pratt: Dr. Webber and the Doctor who seconded it, withdraw the motion. Before I call on Dr. Carter, I think that Dr. Hill has something that he would like to present to us. Do you have anything you would like to bring out, Dr. Hill, at this meeting?

Dr. Frederick T. Hill, Waterville, Chairman Committee on Graduate Education: Dr. Pratt, you have in mind what I wrote you about?

Chairman Pratt: Yes.

Dr. Hill: It is on the matter of Public Relations. The point, gentlemen, is this. . . .

Chairman Pratt: Dr. Hill, I would like to see a resolution introduced that this committee be given funds to work with, pursuant to the authority or endorsement of the Council, and that will give you a break on the committee. Let the Council allocate funds for this purpose. Do you make a motion?

Dr. Hill: I can't, I am not a House Delegate.

Dr. Kinghorn: I will make that motion.

A Member: I will second the motion.

Chairman Pratt: A motion has been made and seconded. Will you repeat the motion, Dr. Kinghorn?

Dr. Kinghorn: Well, I think perhaps you had better let him make the motion.

Dr. Hill: Well, I suggest that the Council be given the authority to expend funds for use of the Public Relations Committee, as they see fit.

Dr. Kinghorn: That is the motion.

This motion was duly seconded and carried.

Chairman Pratt: I think Dr. Carter has one or two matters that he would like to present at this time.

Dr. Carter: Mr. President and members, this is a resolution brought by your President-Elect, Dr. Pratt, for the National Health Program, which is the Wagner Bill that is now being brought in Congress:

"Resolved: That, in the opinion of the Maine Medical Association, the Wagner Health Act proposes a revolutionary change in the practice of medicine which is not justified by reliable evidence; that the cost of the proposed legislation would be tremendous and indefinite; that it is impossible to amend the Act so as to make it workable; that our Senators and Representatives in Washington be informed that the Maine Medical Association urges them to oppose the passage of the Act."

Chairman Pratt: You have heard the resolution proposed. Perhaps it is needless to say I am in favor of it. I should think that the proper thing to do with this resolution would be to refer it to the Committee on Resolutions.

Dr. Foster: I so move.

Chairman Pratt: Dr. Foster moves that the resolution be referred to the Committee on Resolutions. Is the motion seconded?

This motion was duly seconded and carried.

Chairman Pratt: Dr. Hill, I think, has another report he would like to make.

Dr. Hill: Last year a special committee was appointed by Dr. Bunker to confer with similar committees from the Maine Hospital Association and the Maine Nurses' Association, to consider the problem of nursing education in Maine. This was a request committee. The following report is submitted:

(Dr. Hill read the report of the committee regarding nursing education in Maine.)*

Chairman Pratt: That is the report of a committee?

Dr. Hill: Doctor, you have a copy of it?

Dr. Carter: Yes, I have.

Chairman Pratt: You have heard the report of Dr. Hill of the committee. What action do you take?

Dr. Oram: I move that the report be accepted.

This motion was duly seconded and carried.

Chairman Pratt: Dr. Carter has another matter.

Dr. Carter: Mr. President and members: This is an amendment to Chapter VII, Section 4, of our by-laws as drawn up by Mr. Herbert Locke, our defense attorney in malpractice cases, and approved by the Council in Session, June 28, 1938, at Bar Harbor.

Chapter VII, Section 4. The Medical Advisory Committee shall consist of seven members and the Secretary. With the consent of the Council a majority of the members of this committee shall be empowered to fill any vacancies that may occur upon that committee. It may assist in the defense of any member sued for alleged malpractice if the member was in good standing and had complied with the rules of the committee when the service on account of which the suit was brought was rendered. It may engage counsel, and may incur such expenses in the performance of its duties as may seem necessary, a final accounting to be made each year to the Council.

Now here is the part that we want to change:

"It may assist in the defense of any member sued for alleged malpractice if the member was in good standing and had complied with the rules of the committee when the service on account of which the suit was brought was rendered. It may engage counsel, and may incur such expenses in the performance of its duties as may seem necessary, a final accounting to be made each year to the Council."

Now he wants that changed so it reads like this:

"It shall be concerned with the legal problems of physicians, particularly claims for alleged malpractice. It shall seek to find and remedy the causes and conditions from which such legal problems, including malpractice, arise. Any member in good standing, accused of malpractice, may lay the accusation before such Committee and have the benefit of its advice. That the Committee may advise soundly, it may engage counsel and incur such expense in the performance of its duties as may seem necessary, a final accounting to be made each year to the Council."

That is to be laid on the table and brought up tomorrow for consideration.

Chairman Pratt: This is an amendment. You have heard the amendment. Will somebody move that the matter be laid on the table and brought up tomorrow afternoon?

Dr. Kagan: I so move.

Chairman Pratt: Dr. Kagan moves that the matter be laid on the table and brought up tomorrow afternoon. Is the motion seconded?

This motion was duly seconded and carried.

Dr. Carter: I have a letter written from the New Brunswick Medical Society addressed to me. This is from their Secretary, A. S. Kirkland.

(Dr. Carter read the letter just referred to.)

A Member: 1940?

Dr. Carter: No, this is 1939.

Chairman Pratt: No action is needed on this communication.

Dr. Foster: Mr. President, while no action is needed, it seems to me it might be courteous to read that invitation before the general session, to the full gathering or the full membership, at some meeting.

Chairman Pratt: Do you make that as a motion, Dr. Foster?

Dr. Foster: As I understood, the invitation was to any and all members of the society?

Dr. Carter: Yes.

Dr. Foster: I move, then, that it be read to the full meeting of the Society.

This motion was duly seconded and carried.

Chairman Pratt: I am sorry to say that Dr. Bliss has just notified me that he is obliged to return home, and he is Chairman of the Nominating Committee. I will appoint Dr. Forrest B. Ames, of Bangor, in his place as Chairman, and I will select another delegate from the Fifth District to take Dr. Bliss' place. I am very sorry that you have got to go, Doctor.

Dr. R. V. N. Bliss, Bluehill, Councilor Fifth District: So am I.

Chairman Pratt: I would like to say that we ought, at some meeting, to have Mr. Locke present to give us a brief resumé of the legal acts, or whatever it is, of the Association during the past year. I will say that in my opinion, although Mr. Locke kept in the background as a matter of policy, I think he did some most excellent work in the Legislature this year. We hope to have him at some other meeting.

Does any member have any other business they would like to bring up?

Dr. Cobb: I would like to say at eight-thirty or thereafter this evening, in this room, we will have an entertainment that will be something different, and I can assure everybody present that the doctors and wives and guests are invited, and they will be treated to something very rare.

Chairman Pratt: Has any other member any business to come before this group?

Dr. Knowlton: Mr. President, I would like to refer back to what we call pre-natal care coming up regarding your legislature thing. I believe you have a Publicity Committee as well as a Public Relations Committee and a Legislative Committee. In view of the new process and the new manner of attack, should there be any amalgamation or consolidation of the three committees, or do they

* Published in the July issue of the Journal, page 183.

all function differently? The new matter, apparently, is going to be a matter of publicity.

CHAIRMAN PRATT: I believe the Publicity Committee is simply a kind of censor of what goes out from this meeting to the press.

DR. KNOWLTON: Mr. Chairman, I move we adjourn.

This motion was duly seconded.

CHAIRMAN PRATT: It is moved and seconded we adjourn until five-thirty tomorrow afternoon.

(Whereupon the meeting was adjourned at six forty-five o'clock in the afternoon.)

SECOND MEETING OF THE HOUSE OF DELEGATES, JUNE 26, 1939

The second session of the House of Delegates convened on Monday, June 26, 1939, at 5.30 p. m., with Dr. George L. Pratt of Farmington, President-Elect of the Maine Medical Association, presiding.

CHAIRMAN PRATT: The Secretary will call the roll.

(The Secretary called the roll and the following delegates responded):

Androscoggin County: W. E. Webber, Lewiston.

Aroostook County: H. E. Small, Fort Fairfield.

Cumberland County: L. A. Brown, W. D. Anderson, Ralph A. Heifetz, D. H. Daniels, Portland; J. C. Oram, South Portland.

Franklin County: C. C. Weymouth, Farmington.

Hancock County: M. A. Torrey, Ellsworth.

Kennebec County: Samuel H. Kagan, Augusta.

Knox County: Howard Apollonio, Camden; A. J. Fuller, Pemaquid.

Oxford County: E. M. McCarty, Rumford.

Penobscot County: L. J. Wright, Henry C. Knowlton, Forrest B. Ames, Bangor.

Piscataquis County: F. J. Pritham, Greenville Junction.

Sagadahoc County: A. F. Williams, Togus.

Somerset County: W. H. Walters, Fairfield.

Waldo County: Foster C. Small, Belfast; Carl H. Stevens, Belfast, Alternate.

York County: S. A. Cobb, Sanford.

CHAIRMAN PRATT: We have a sufficient number to do business. I would like to ask you again when you speak, unless you are called upon by name, to state your name when you get up. It helps the reporter. We always say that and then no one does it. I think it would be a good idea if you did do it.

The first article of business is the Report of the Nominating Committee; Dr. Forrest B. Ames of Bangor.

DR. FORREST B. AMES, Bangor, Chairman Nominating Committee: Mr. President and Delegates: The Nominating Committee offer the following names for the committees for 1939 and '40:

(Dr. Ames read the list of nominations for the various Standing and Special Committees.)*

DR. AMES: As delegate to the 1940 Session of the American Medical Association, we present the name of W. A. Ellingwood of Rockland. The Committee further recommends that a suitable Alternate Delegate to the American Medical Association be appointed by the Council. Respectfully submitted by the Committee on Nominations.

CHAIRMAN PRATT: Dr. Ames, we think the A. M. A. delegates should be appointed for two years.

DR. AMES: Two years?

DR. CARTER: Two years; that is right, Doctor.

CHAIRMAN PRATT: I think that is satisfactory.

DR. AMES: Yes, indeed.

CHAIRMAN PRATT: You have heard the report of the Committee on Nominations. What will you do with it?

A MEMBER: I move the report be accepted.

This motion was duly seconded.

CHAIRMAN PRATT: It is moved and seconded that the report be accepted.

DR. WILLIAMS: I make a motion that the Secretary cast a ballot.

This motion was duly seconded.

CHAIRMAN PRATT: Did you make both motions, Doctor, or did you just add to the motion?

DR. WILLIAMS: Well, I understood his motion was to accept the report, and I amended it that the Secretary cast a ballot.

CHAIRMAN PRATT: I will present the motion as amended and seconded. Is there any discussion?

This motion was duly carried.

CHAIRMAN PRATT: The Secretary will cast a ballot for the Committees elected. Dr. Hill has a matter he would like to present at this time.

DR. HILL: Mr. Chairman and members of the House of Delegates: The Committee on Graduate Education this year presented a recommendation in the report as published in the JOURNAL, to the effect that this Association actively participate in the New England Post Graduate Medical Assembly. This is at the request of the original sponsoring body, the Massachusetts Medical Association. I had a conference with Dr. Ober over this and they are very anxious that the state associations come into this so they can make it purely a New England Post Graduate Assembly rather than a Massachusetts creation alone.

Therefore, your Committee has made this recommendation, and we would like to suggest the following motion: That the Maine Medical Association participate as an organization in the New England Post Graduate Medical Assembly, and that the Committee on Graduate Education be authorized to act for the Association in matters relating to said New England Post Graduate Medical Assembly.

DR. C. C. WEYMOUTH, Farmington: I make the motion that the motion of Dr. Hill be made and seconded.

This motion was duly seconded by Dr. Knowlton, and carried.

CHAIRMAN PRATT: The next article of business is the report of the Reference Committee, by the Chairman, Dr. P. L. B. Ebbett of Houlton.

DR. P. L. B. EBBETT, Houlton, Councilor from the Sixth District: The following resolution has been handed to the Reference Committee:

"That, in the opinion of the Maine Medical Association, the Wagner Health Act proposes a revolutionary change in the practice of medicine, which is not justified by reliable evidence; that the cost of the proposed legislation would be tremendous and indefinite; that it is impossible to amend the Act so as to make it workable; that our Senators and Representatives in Washington be informed that the Maine Medical Association urges them to oppose the passage of this Act."

Now the Reference Committee believes that this resolution should be adopted by the Maine Medical Association.

CHAIRMAN PRATT: You have heard the recommendation. Do you make that a motion, Doctor?

* Published in the July, 1939, issue of the JOURNAL, page 182.

Dr. Ebbett: I would make a motion that the Maine Medical Association adopt that resolution as read.

This motion was duly seconded by Dr. Webber.

Chairman Pratt: You have heard the motion which was seconded by Dr. Webber. Is there any discussion?

Dr. Knowlton: Mr. Chairman, it seems to me that probably this Wagner Act will be passed whether we like it or not. And I am rather loath for us to send in any such resolution as that to our Senators and Representatives. In the first place I don't think it will do any good, and in the second place I think it will be interpreted, especially if it receives any publicity at all, that we are, however correctly, getting in the way of what is going to be taken as progress.

Agreeing perfectly with the President-Elect that the Act isn't justified, I think it is rather poor publicity to air our views at all in a public place, at least this year, and I don't think it is going to do any good anyway.

Chairman Pratt: Is there any further discussion.

Dr. Foster: Mr. Chairman, may I ask to have the resolution reread?

Chairman Pratt: I will ask Dr. Carter to repeat the resolution.

(Dr. Carter then reread the resolution.)

Chairman Pratt: Do any other members wish to discuss this matter.

Dr. Oram: I think our feeling in this matter is perfectly justified economically, and I think it is better for the patient to go the way things are, as they are. But Dr. Knowlton has brought out a point which people will certainly grab on and hang onto like a dog to a bone.

I think we could get much more action from our Representatives and Senators in Washington if the medical men would write to them, and the Lord knows they won't do it because they feel they can't waste their time looking out for their own fortunes, which will soon become misfortunes.

Dr. Ellingwood: Dr. Oram said a mouthful. This has been before the committee on May 25. We sent a committee from the American Medical Association down to Washington and if you have read your Journals you have seen what has gone on. Now I believe what Dr. Oram has said is really better than any resolution we could pass as an organization.

Now I will tell you why I think so. It is from the experience we have had in our own Legislature in regard to the bills that the osteopaths have entered, whereby every osteopath has written a letter, and they have had their clients or their patients write in to their Representatives. And the medical man, as Dr. Oram said, either doesn't know how to write or hasn't had the time.

I doubt very much if this resolution would be of any great benefit, but I do believe that if we, as representatives of this organization, would write to our Senators and Representatives, it might have considerable bearing. That might be well to consider before we pass on it.

Dr. Foster: The report of the Council, you may remember, instructed the Chairman to communicate with the Senior Senator of this State and present the views of the Society on the National Health Act. That was done, and in consultation with Mr. Hale I found that he, as Senior Senator, was against the Act and expected the whole Maine delegation would be against the Act. Of course, he was not in a position to make any pledges or commitments for the other members of the Maine delegation, but he did tell me that he felt they were distinctly against it.

I am inclined to agree with Dr. Knowlton and Dr. Oram, that any resolution from this organization may antagonize the public more than it will aid the defeat of the measure. I should favor simply consideration of the resolution, and if the delegates decide to pass such a resolution I would favor modifying it to the extent of qualifying it in its present form.

My point is, as I think Dr. Knowlton expressed it, that strategy such as that resolution is not as effective as individual expression of opinion.

Dr. Hill: Mr. President, may I have the floor for a few minutes?

Chairman Pratt: You may.

Dr. Hill: This resolution will be in awfully good company, because a number of other large organizations are doing the same thing. And probably the one man who is going to do more to kill this Wagner Bill when it is killed, is the head of the Catholic Hospital Association, who has come out emphatically against it; and you notice the odds in Washington are now eight to two against the Wagner Bill being passed.

I feel perhaps this is as effective as anything. I certainly feel the Association should protest against it; but wouldn't it be very effective for the President of the Association to communicate, as President, personally with each member of the delegation, saying it is the view of the Maine Medical Association that the bill be not passed. The protest is not bad.

Chairman Pratt: Is there any other discussion?

Dr. Webber: Mr. President, I wonder if the politics of Washington would be like the politics of the State in the matter of opposition to the medical profession?

In the first place, this bill is a social bill. While, of course, it primarily affects the doctors, it is not in its text aimed at the doctors. It is more particularly aimed at the social condition, and to improve, as the argument goes, the condition of the laity. It seems to me that a protest of this kind by the Association would do some good. I can't see why it should do harm.

I can see how we, in our own State Legislature, always have been worse off by the doctors' protesting these things than had we stayed at home, because they have thought it was professional jealousy. Now in this instance I can't see that they could feel that it was professional jealousy and I should feel that a protest like this from the Association would do some good.

I know, as well as you all know, that a political thing of that sort is carried on *sub rosa* more or less, and a good deal more than less, and that the protests of organizations as such do not weigh as heavily as individual protests do. But I can't see where this would do any harm, and it certainly shouldn't prevent any of us writing to our Legislator if we saw fit. I feel that the majority of us are too lazy to do it, but a few will, and it seems to me that this thing should go through.

Dr. Knowlton: Mr. President, if I may state just a word?

Chairman Pratt: Dr. Knowlton.

Dr. Knowlton: Mind you, I am not in favor of the Wagner Act. We are, however, a small organization, part of the American Medical Association. The American Medical Association, as you know, is under indictment; we don't stand in at all as a group. If we sit down and write our protests as any voter has a right to do, to our Representatives

and Senators, we would carry some weight. If we send in a resolution, we do nothing but publicize ourselves if the bill is passed, or whether it is passed or not; we get ourselves out on the limb for our opponents to saw off the limb behind us. That is my point about it.

Dr. Foster: Mr. Chairman, I would like to hear from the Chairman on this matter, if he feels willing to speak.

Chairman Pratt: I was going to, if you will permit me to, after everyone else had spoken that wanted to. I would like to say that in my opinion, if we think this bill is wrong, we ought not to be afraid to say so. I think if we make individual protests they will be a good deal more effective, if we say that we have the opinion of our organization behind us.

The New Hampshire State Society passed a similar resolution. They voted to instruct their delegates to either oppose or drastically amend the Act. Our resolution says it is impossible to amend the Act. In the testimony before the committee in Washington which is conducting the hearings now, and before which the American Medical Association is getting its first opportunity to have anything to say, it was said that three hospital associations, and one of them was the American Hospital Association, had attempted to amend the hospital clause alone of this Act. After they had got up to fifty or more amendments, they quit. The Act is so long and so cumbersome and so involved that in my opinion it is impossible to amend it.

I have great respect, as I said, for the opinion of the gentlemen who are afraid we might do some harm. I don't believe we will do any harm. We will take the stand if we do, and we should. I hope the resolution will pass.

Is there anything further at this time?

Dr. A. J. Fuller, Pemaquid, Secretary Knox County Society: Mr. Chairman, in a case like this where Dr. Fishbein is going to be present tomorrow and the delegates are not meeting after his presence here, would it be possible if Dr. Ebbett withdrew his resolution before the House of Delegates, to leave it to the Secretary or the Chairman of the House of Delegates to proceed as he saw fit with this resolution after talking with Dr. Fishbein, to see whether it will be more advantageous or not?

Chairman Pratt: I think that might be possible.

Dr. Ralph A. Heifetz, Portland: Mr. President, I think perhaps it would be a little bit more tactful to pass that resolution before he did come down. I don't know how many of you have read this report in the American Medical Journal, at least the last two Journals; but in view of Dr. Ebbett's stand and Ex-Senator Hodge's stand, I think Senator Wagner has shown a lot of persistence.

In view of the Wagner Act not being amended, I think they felt that another Act written, or rather another National Health Act written another way, might be suitable to the American Medical Association.

It makes you feel if we pass that resolution before he came down, it might show him exactly where we stood on it.

Dr. Ebbett: I might say this resolution is not one I proposed. This is not my resolution. I am merely Chairman of the Committee. That was passed to us for consideration, to the Reference Committee for consideration, believing that this Society should take some definite action and some definite stand. If it is left to individuals there will be a half a dozen letters which wouldn't amount to much. But I believe this Society should stand behind this thing as a whole. Then if members will be so good as to write their Representatives, I think it will help the thing along very much. But if only a small proportion wrote, it wouldn't amount to much. In my opinion there would be very few letters going to our Senators unless we take some action.

Dr. Fuller: Mr. Chairman, I am heartily in favor of this resolution being sent in, but I didn't know but what, owing to the discussion, it might be better if it were left to the discretion of the Chairman to do as he saw fit with the authority back of him, after talking with Dr. Fishbein about the advantages of it.

Chairman Pratt: I don't think anything will be done with the resolution anyway until after we talk with Dr. Fishbein. We will show him the resolution, and if he advises us to keep it under cover we will do so.

Dr. Kagan: Mr. President, there is another view on this line which in preliminary parleys is very important. If we do not pass any opinion on the matter, undoubtedly the followers of the bill will say, "Well, there is Maine; the doctors up there haven't opposed the bill." I think that is an attitude you must consider. We have got to go on record one way or the other.

Dr. Weymouth: I quite agree that this bill or resolution should be passed, and I think we should express ourselves and not be afraid to do it. I think in addition to the Association expressing itself in opposition to the Wagner Bill, that each member still can write and exert their power in opposition to it. I firmly believe that we should do our part in opposition to the bill.

Dr. Cobb: Question.

Chairman Pratt: The question is called for. All those in favor of passing the resolution please raise their right hand. Those opposed? It is a vote.

Dr. Knowlton: You had better make it unanimous.

Chairman Pratt: I will now ask for the report of the Delegates from the First District for nomination of Councilor. Do you have any nominations to make from the First District for Councilor?

Dr. Oram: Mr. President, I think the Medical Association elected a most excellent Councilor from our District, and we want somebody who will fill his shoes equally well. And the delegates from that District feel that Dr. Stephen A. Cobb will be an excellent man; therefore we place his name in nomination for Councilor of this District.

A Member: Second the nomination.

Chairman Pratt: The nomination is made and seconded that Dr. Stephen Cobb be Councilor from the First District. Any other nominations? If not, all those in favor of the nomination of Dr. Cobb please raise their hand. Opposed? (Applause.)

(There was no opposition.)

A Member: Speech!

Chairman Pratt: Dr. Cobb is elected. If he is here we will call upon him for a speech.

Dr. Cobb: Mr. Chairman, I haven't any speech to make in being raised to this office, but I have something I would like to say. Two years ago we had Ken Roberts and the bogus doctor from the land of Italy, and last night we had a wonderful entertainment by Dr. Romano of New York City. All three of these speakers came to our Association meetings without a cent of expense to the Association, through the kindness of Jim Campbell who has no political aspirations, and I don't think he will get much advertising for his Palm Beach cloth, sending them to our Association. He has done that for his friendship to me and love for

the medical profession. He has always been sorry he wasn't a doctor. He has always said after he made a million dollars he was going to study medicine.

I think it would be a fine gesture for this Association to send Colonel Jim a nice letter of thanks.

Dr. Knowlton: I so move.

This motion was duly seconded and carried.

Chairman Pratt: I will say Councilors are elected to do a lot of work for nothing. And Dr. Cobb has demonstrated he is a good worker for the last several years.

I will now ask for nominations for the Second District.

Dr. Ames: The delegates would nominate Dr. McCarty of Rumford Falls.

Chairman Pratt: Is the nomination seconded?

Dr. Knowlton: Seconded.

Chairman Pratt: Are there any other nominations? All in favor of the election of Dr. McCarty as Councilor from the Second District, please signify by saying "aye."

(There was a chorus of "ayes" and the motion was carried.)

Chairman Pratt: It is a vote, and Dr. McCarty of Rumford is elected Councilor of the Second District. If he is here I think he ought to make a speech.

Dr. E. M. McCarty, Rumford: Mr. President, I am not a speech-maker, but I will say this. I will try to put a little time in, and tag along as best I can. (Applause.)

Chairman Pratt: There are several delegates to other societies who were not present yesterday, and I call on the delegate to Massachusetts, Carl M. Robinson.

Dr. Carter: Mr. President, Dr. Robinson was called away about half an hour ago, and he wished me to say to you and the members that he attended the meeting in Massachusetts. He was royally entertained and enjoyed it very much, and he thanks us for sending him.

Chairman Pratt: Delegate to Rhode Island, George R. Campbell.

Dr. George R. Campbell, Augusta: Mr. President, I want to thank the Association for sending me down there. I had a very enjoyable time. The meeting was held in the Rhode Island Library in Providence, which the Association owns, and they held clinics in the mornings of two days, and in the afternoons there were papers which took most of the afternoon.

One of the highlights of the first day was a paper by Marshall Fulton, Associate of Medicine of Harvard Medical School.

(Dr. Campbell read a list of speakers and their subjects at the Rhode Island Medical Association meeting.)

In the morning clinics were held at the various hospitals, and in the evening of the last day the banquet was held. And last but not least, the speaker was Dr. Reginald Fitz. (Applause.)

On the whole it was a very interesting and instructive meeting.

Chairman Pratt: Thank you, Dr. Campbell. The delegate to Connecticut, Eugene O'Donnell of Portland.

Dr. Foster: Mr. Chairman, I talked with Dr. O'Donnell, who is a graduate of Yale Medical School, and was delighted to have an opportunity to attend a meeting of the Connecticut Medical Society. He reports he had a delightful time, was royally entertained as Dr. Carter said, and in every way pleased with having the opportunity of attending the meeting.

Chairman Pratt: Delegate to Vermont, Foster C. Small.

Dr. Foster C. Small, Belfast: Mr. Chairman and House of Delegates: I attended the Vermont Medical Society meeting last fall and had a fine reception. There was fine entertainment and I was well received. I was especially pleased to represent the Maine Medical Association, for which I thank you.

The scientific sessions were all held in the Hotel Vermont, and the chief subject that was really a highlight of the entire session was the discussion of gall bladder diseases, giving the histology, pathology, physiology, medical, and non-surgical treatment, conducted by Dr. Gordon, I believe, of McGill University. It was well worth hearing, very instructive, and especially well presented.

The other sessions were held in the main dining room of the Hotel Vermont in the evenings. We had a very fine banquet, and the closing session was more of a social occasion and was not a scientific program. We just had debaters and had a real fine, good time. And again I want to thank you for having the privilege of going.

Chairman Pratt: Thank you, Dr. Small. That is an excellent report.

There are two of the Councilors whose reports didn't get into the Journal in time to be printed, and I will call on Dr. Carl Stevens, if he has a report from his District.

Dr. Carl H. Stevens, Belfast, Councilor from the Fourth District: Mr. President and Members of the Association: As Councilor of the Fourth District, comprising Kennebec, Somerset and Waldo Counties, it is my privilege to report that during the last year all three Societies have been active. They have had many well-arranged and well-attended meetings.

Two of the meetings I attended seemed to me to be unusually interesting, and they were furnished by two panel sections, one on pneumonia, the other on fractures.

As you may know, Waldo County is a small county and has a small membership. But I asked Dr. Torrey, who is a live wire and I think measures up very well as a secretary, to give me a brief résumé, and I really was surprised myself to find what we have done in that little county in the last year.

We have had joint meetings with Hancock and Knox Counties on some occasions. At the September meeting Dr. Roland Moore of Portland and Dr. Mitchell of the State Bureau were present and gave a program on obstetrics. In November there was a joint meeting with Hancock County at Ellsworth, and the second part of this program was presented on obstetrics by Dr. Moore and Dr. Jewett.

At the second meeting in Belfast, Dr. C. B. Popplestone spoke on Electrocardiography, and Dr. Philip Wood spoke on Vitamins and the results from some of them. Later a joint meeting of Waldo, Knox and Hancock was held at Belfast, and there the panel discussions were under the chairmanship of Dr. Allan Woodcock of Bangor.

In April they had an A. M. A. sound picture on Syphilis, which was an unusually good program. We were able to put that on by procuring a sound moving machine from a Camden High School.

All in all I believe that the Fourth District has had a very successful year. Thank you.

Chairman Pratt: Thank you, Dr. Stevens. I

will call on the Councilor from the Second District, Dr. Bolster. Dr. Bolster is not here.

We have several committees whose reports were not published and the Chairmen were not here yesterday. I will call on Dr. George R. Campbell of Augusta for report on the Public Relations Committee. Is Dr. Campbell here? He has just gone out.

Committee on Social Hygiene, Dr. E. S. Merrill of Bangor. Dr. Merrill is not here.

Dr. M. C. Moulton, Chairman of the Committee of Representatives of Appointed Hospital Staffs.

Dr. Knowlton: He is not here.

Chairman Pratt: Committee on Maternal Welfare, Roland B. Moore, Chairman. He is not here.

Dr. Carter has a matter he would like to bring up.

Dr. Carter: This is the amendment that was presented to you yesterday, laid over in that meeting, and is taken up today for your consideration. Amendment to Chapter VII, Section 4, of the By-Laws, presented by Mr. Locke and approved by the Council in Session June 28, 1938, at Bar Harbor. It reads as follows:

Chapter VII, Section 4. The Medical Advisory Committee shall consist of seven members and the Secretary. With the consent of the Council a majority of the members of this committee shall be empowered to fill any vacancies that may occur upon that committee. It may assist in the defense of any member sued for alleged malpractice if the member was in good standing and had complied with the rules of the committee when the service on account of which the suit was brought was rendered. It may engage counsel, and may incur such expenses in the performance of its duties as may seem necessary, a final accounting to be made each year to the Council.

Now here is the part we want to change:

"It may assist in the defense of any member sued for alleged malpractice if the member was in good standing and had complied with the rules of the committee when the service on account of which the suit was brought was rendered. It may engage counsel, and may incur such expenses in the performance of its duties as may seem necessary, a final accounting to be made each year to the Council."

Now he wants that changed so it reads like this:

"It shall be concerned with the legal problems of physicians, particularly claims for alleged malpractice. It shall seek to find and remedy the causes and conditions from which such legal problems, including malpractices, arise. Any member in good standing, accused of malpractice, may lay the accusation before such Committee and have the benefit of its advice. That the Committee may advise soundly, it may engage counsel and incur such expense in the performance of its duties as may seem necessary, a final accounting to be made each year to the Council."

Mr. Locke was before our Council and explained last year, as I remember it, just why he wanted that change made. I don't remember the particulars at this time.

Chairman Pratt: I think we all agree that whenever Mr. Locke asks for a change, his reasons are good.

Dr. Webber: I move we pass it.

Dr. Knowlton: I second the motion.

Chairman Pratt: Dr. Webber moves and Dr. Knowlton seconds the motion.

This motion was duly carried.

Chairman Pratt: The next article of business is an invitation to the 1940 Annual Session. I would like to say that this matter, as to time and place, has generally been left to the Council, but the House of Delegates has the power to decide now, if they wish to. I think Dr. Carter has an invitation, one or more, to read.

Dr. Carter: This letter I received June 12, 1939, from Mr. Charles B. Day, the Manager of the Rangeley Hotel. It reads as follows:

(Dr. Carter read letter of June 12, 1939, from Mr. Day.)

Dr. Carter: I will say that he came to the hospital and interviewed me relative to the meeting next year, and I said, "The only thing that I can say, Mr. Day, is if you will send us your proposition I will present it before the proper authority."

Dr. Weymouth: Mr. President, I think, since it has been the custom to leave this with the Council, that I would make a motion that it be left with the Council this year. Of course, we are doubly anxious to have it in Rangeley, and I think everybody knows what Rangeley has to offer, not only in the way of golf, but lake sports and what-not. No doubt they would choose that. I make a motion it be left with the Council.

Dr. Webber: I second that motion.

Chairman Pratt: The motion has been made and seconded that it be left with the Council. Is there any discussion?

Dr. Kagan: Mr. President, is there any definite plan or idea as to successive places of meetings? I mean, do you go according to having the meeting, say, in District 1, 2, 3, 4, 5, 6?

Chairman Pratt: No, there is no definite rule.

Dr. Kagan: There is no possibility of having the whole state represented in sequence, then? I think that is a thing that the Council ought to take into consideration.

Chairman Pratt: I think I ought to say to Dr. Kagan, there are only a few places in the State where they have places large enough. The Council voted, or the Association voted, several years ago to have these annual meetings at one of the summer resorts: Poland Spring, the Marshall House at York Harbor, and the hotel down in Bar Harbor, and Rangeley, are about the only ones that are large enough to accommodate the crowd.

Dr. Kagan: That answers the question.

Chairman Pratt: Does anyone else wish to discuss the matter? If not, all those in favor of Dr. Weymouth's motion please signify it. Opposed?

(There was a chorus of "ayes" and the motion was carried.)

Dr. Cobb: Mr. Chairman, your Program Committee has tried hard this year to make it more or less interesting for the ladies. Now out there tonight at supper I have a big place laid out in the dining hall, and we are going to have dancing after the dinner. We have a fine orchestra, and I want you fellows to help me out and see that our ladies do not become wallflowers during the evening.

And I want to say shortly after nine we have another fine speaker this evening, and if you enjoyed the show last night, I believe Dr. Greene will put on just as good a show tonight, and I will feel well repaid by your attending this session this evening.

Chairman Pratt: Thank you, Dr. Cobb. I would like to say, we have with us one of our speakers of tomorrow afternoon, Dr. John J. Moorhead of New York, and I would like to have him stand up so you will all know who he is. (Applause.) You

will probably hear all you want to from him tomorrow afternoon.

Does any member have any new business he would like to offer?

DR. FOSTER: Mr. Chairman, before we adjourn I would like to report that Mrs. Kennard asked me to tell the Council to remain in this room after the meeting. It may be you were going to ask that, anyway. Mrs. Kennard asked me to remind you.

CHAIRMAN PRATT: I thank you, I had forgotten it. The Council will meet here to organize?

DR. FOSTER: That is right.

CHAIRMAN PRATT: If there is no other new business, a motion is in order to adjourn.

A MEMBER: I move we adjourn.

This motion was duly seconded and carried.

(Whereupon, the meeting adjourned at six-twenty o'clock in the evening.)

ELECTION OF THE PRESIDENT-ELECT

The meeting convened on Monday, June 26, 1939, at five five p. m., with Dr. Willard H. Bunker, President of the Maine Medical Association, presiding.

PRESIDENT BUNKER: Will you come to order, please?

DR. CARTER: Please be seated.

PRESIDENT BUNKER: Gentlemen, nominations for President-Elect of this Association are in order.

DR. PHILIP P. THOMPSON, Portland: Mr. President, it gives me great pleasure to nominate Dr. Thomas Foster, Portland, for President-Elect. He comes from a line of well-beloved physicians. His father was President, I think, of this Association in 1909, and he has served several years on the Council, so he is not only well-liked but well-fitted for the office.

DR. W. E. KERSHNER, Bath: Mr. President, it gives me great pleasure to second the nomination of Dr. Thompson. I have known Dr. Foster for a number of years and I have known him fairly intimately under certain conditions, and I assure you gentlemen in honoring him the Society is honoring itself. I second the nomination. I move that the nominations cease and that the Secretary cast a ballot for Dr. Foster.

PRESIDENT BUNKER: Gentlemen, you have heard that nomination; all those in favor of the motion will please say "aye." (There was a chorus of "ayes" and the motion was carried.)

I will ask the Secretary to cast one ballot to elect Tom Foster President-Elect of this Association

(The Secretary cast one ballot.)

Is Dr. Foster here?

MEMBERS: Speech! Speech!

DR. THOMAS A. FOSTER, Portland: Mr. President and Members of the Convention, I thank you. And I accept with gratitude the opportunity of serving you in the high office to which you have elected me. It seems as though I have known some of the members of this Society always, since I can remember. I have known some for a great many years, and some for a shorter time. I hope in the next two years I will know everybody by name and know them as well as I know some of the older members.

I will strive to carry on the traditions of the Society in the high standards which have always been maintained. I might say to some of you, especially those of you who were at Belgrade and Bar Harbor, I hope I can make arrangements to have a Committee appointed to confer with the weather man and next year have blue skies and lovely sunshine when we meet. Thank you. (Applause.)

PRESIDENT BUNKER: A very fine speech, Tom. I think there is nothing more at this time, gentlemen.

DR. CARTER: The meeting of the House of Delegates.

PRESIDENT BUNKER: A meeting of the House of Delegates will take place immediately in the private dining room.

(Meeting adjourned at 5.15 p. m.)

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*The Small Community Hospital as a Teaching Hospital**

J. T. Morrison, M. D., New York City

I want to preface my remarks today with two stories illustrating the search for an idea and birth of an ideal.

Several years ago, when visiting one of the hospitals sponsored by the Commonwealth Fund, I had occasion to discuss with several staff members plans for continuing staff education. We discussed at some length the clinical records and the necessity of recording the events of patient illness in some detail in order to make them valuable for staff study. We discussed the use of the laboratory and the X-ray department, autopsies, and the development of a minimum standard of diagnostic procedure at the hospital. One of the staff members remarked that he did not see the need for detailed clinical records, diagnostic procedures, high percentage of autopsies or Journal Clubs in the small community hospital because, after all, it was not a teaching hospital. This remark led to quite a discussion of the subject of teaching hospitals. Just what is a teaching hospital and why is it a teaching hospital? And why cannot a 50-bed community hospital render a service on the firing line, as it were, of medical practice such as is rendered by a teaching hospital?

I continued my inquiries in a number of similar hospitals. I found it to be the consensus of opinion that a teaching hospital is a hospital organized for the purpose of undergraduate teaching and intern training and attached to, or administered by, a medical school. Such a hospital is thoroughly organized into medical and administrative departments, each with its own chief who directs its efforts, supervises its work, and inspires its teaching activities. The staff at such a hospital naturally gives attention to the detail of clinical records in order to develop a basis for medical literature: establishes a minimum standard of diagnostic procedure as a guide for those ministering to patients: makes detailed laboratory and X-ray studies of each patient to support the clinical findings and study the effects of disease; arranges for clinical pathological conferences or staff conferences to pool experience; and organizes seminars and journal clubs which all staff members must attend. All this was considered necessary in a teaching hospital, as general opinion visualized such an institution, in order to teach undergraduates and interns the best medical practice, the most scientific approach to the study

* Read at the 87th Annual Session of the Maine Medical Association, Poland Spring, Maine, June 27, 1939.

of illness, and the methods of seeking and obtaining medical information.

This conception of a teaching hospital would not fit the small rural hospital. It laid emphasis on a pyramid type of staff organization and placed responsibility on the department heads for the continued study of the art and science of medicine. So I sought another lead, and it was not long until I found it. A resident physician, bubbling over with enthusiasm, remarked to me in discussing his work in a small fifty-bed community hospital that—and I quote his words—"There is so much clinical material available at the hospital that I need at least thirty-six hours in every day in which to study it, to do the patient justice and to make it most valuable to me." His use of the two concepts, clinical material and study, struck me at once as fundamental and a real lead in developing the teaching ideal as it applies to the small hospital. Teaching is based on the study of illness. What is there in environment causing it and how can it be most successfully diagnosed and treated. Therefore, in attacking these problems a teaching hospital should be found wherever there is a patient in a hospital and wherever there are inquiring minds on the staff of physicians attending the patient. Following this ideal, staff members approaching the study and care of illness with the spirit of critical analysis of each patient, should be able to make teaching material from even the so-called routine medical work they are called upon to handle in their day-to-day hospital practice. What about instructors? Several universities have already recognized that an inquiring mind on the battlefront of general practice can contribute experiences which are valuable in teaching. These universities give their undergraduates a period of apprenticeship with general physicians working as a group in a small hospital. What about students? I do not think anyone will take issue with the statement that, when we diagnose and care for illness in human beings, we are all students.

Let us examine, with this concept of a teaching hospital in mind, some of the basic features of a small community hospital that can make it a teaching hospital. I am referring in my discussion to the community type of hospital and to a hospital of approximately fifty beds. This limitation is made largely because this type and size of hospital has supplied me with the material for this discussion. In a larger sense, however, I am referring to any hospital which provides a service to all patients and physicians of the community and supplies effectively, so far as is possible, the variety of services and facilities and the means for their ready use, which contribute to a well rounded medical service to the community.

Medical practice is made up of art and science, the whole based on the exercise of medical judgment by a trained human being. Since the doctor is a human being, the judgment he brings to the practice of his profession is not infallible. He sees a patient and discusses the illness with him. He makes a physical examination to determine through his training and experience the physiological changes which have taken place. Having arrived at a tentative conclusion as to the illness, he calls upon laboratory X-ray and other aids to support his judgment or to suggest another approach to the problem. Receiving reports from these technical aids, the clinician formulates his conclusion on the basis of his past experience and that of others and proceeds with his treatment. Subsequently, in quite a number of instances, he has the opportunity to observe the effects of his treatment and to judge his own work. The whole then becomes a part of this individual physician's experience.

Since the care of the patient is medical practice and the acquisition of experience important, one of the most important steps in teaching is the pooling of the individual experience of each physician with that of others in a common fund of knowledge. In the community hospital where there are no department heads and the staff organization is horizontal this can be done best in the hospital staff meeting, provided, of course, the staff members approach their meeting with the spirit of critically analyzing and freely discussing their experience. Staff leadership in terms of individuals may be officially vested in elected chairmen and appointed committees, but staff leadership providing the stimulus for a high quality of medical work is unofficially vested in the consensus of opinion

of the staff as a group. A concerted will to share experience, submerge individual personalities, and establish a real give-and-take of critical judgment is the only sound basis for a teaching hospital.

Let me illustrate my point by two stories from small community hospitals. As I approached a certain hospital, a physician came through the door almost at a run, "I haven't time to stay and talk now; I have to do an autopsy on a former patient of mine in a nearby city. I operated on this patient some two weeks ago, and she died at home on the second day after her return from the hospital. Do you think I could come to staff meeting without an autopsy report to show the cause of death?"

In another hospital a physician presented the clinical record of one of his patients who had been very ill. The patient, a little girl, had been admitted to the hospital with a pain in her right side. The laboratory report indicated a very high white count. A diagnosis of acute appendicitis was made and an operation performed. At operation a normal appearing appendix was removed. Subsequent examination of the patient disclosed a lobar pneumonia of the right side. The patient recovered after a very difficult convalescence. This physician wished to present this instance to the staff in order that they might profit by his experience. I may add that following this experience the staff set up a diagnostic routine requiring an X-ray of the chest before operation in every instance of suspected abdominal pathology in children below the age of fourteen as a measure of general protection to future patients and themselves from such a happening.

The hospitals from which these stories are taken, to my mind, are teaching hospitals. Every physician of the staff is both instructor and pupil.

I have referred above to the diagnostic routine established by one staff as a result of an adverse experience. The establishment of such a diagnostic standard is another step in the development of a teaching hospital. In the large teaching hospital devoted to undergraduate teaching these standards are regarded as a routine. They describe the desired contents of the clinical record in each general type of illness and list the laboratory and X-ray or other more specialized studies to be made in each instance. Such a routine is a standard for undergraduates, interns, residents, and members of the staff to follow to assure the patient and physician the most complete study of illness, and to protect both, as far as is mechanically possible, from human error in judgment. In most instances this routine is established by the leader of the service. In the small community hospital there is no individual leader of the service. There is, however, the collective staff opinion which can provide equally valuable leadership. In many small community hospitals with which I have contact the staff as a group has prepared a minimum standard of diagnostic procedure for each type of illness likely to be admitted to the hospital, saying in effect that in their opinion a patient's illness has not been adequately studied unless the established basic procedure has been followed. In illustration I would first refer you to the standard mentioned before in the case of the child with an abdominal condition which was found to be caused by pneumonia. In this same hospital, if a patient with a suspected pneumonia is admitted, sputum is at once typed to determine the organism responsible and an X-ray picture made, all in addition to the usual blood counts, urine analysis and a test for syphilis. Many of the hospitals also require that all patients for major operation other than emergency must be in the hospital at least sixteen hours before operation to permit analysis of the illness and adequate preparation for operation. A patient entering such a hospital knows that under the standard of the hospital a real study of his illness will be made before therapy is undertaken. He knows that his illness will receive the benefit of collective opinion of the entire staff. The staff in setting up such a standard makes each individual member responsible to the staff as a group for the maintenance of good quality of medical work. In setting this standard the staff is establishing a teaching hospital.

A staff that pools its experience in staff meeting and that sets up a minimum standard of diagnostic and therapeutic practice will quite naturally give attention to the development of another activity which, for want of a better word, is called "consulta-

tion". The word "consultation" sounds much too formal to me in describing the informal interchange of thought and experience between staff members in their day-to-day hospital experience. The minimum standards may specify that all instances of serious illness likely to result in death, or the interruption of a known, suspected, or possible pregnancy, etc., shall have the benefit of written consultation with another staff member. Consultation in these instances may be formal, and special forms may be used for recording the consultant's opinion. The majority of consultations, however, are quite informal, two or more physicians of the staff viewing the patient and studying the illness as a complete entity with the added knowledge of the patient's home life in the community to assist them in reaching a conclusion. For future reference, the second physician adds a note in the progress notes to indicate his findings, his line of thought, and his conclusions, but the real interchange of information takes place in the corridor or the staff library. In other words, patients admitted to the hospital have the benefit of the experience of more than one of the physicians of the community. In one community hospital 25 per cent of all patients admitted last year had the benefit of written consultation as determined from the clinical records. Such a report of written consultations indicates the possibility that at least another 25 per cent of patients had the benefit of consultations which were not recorded. The hospital is a teaching hospital.

I have referred several times before to the clinical record of which the written consultation becomes a part. Much has been said to physicians about the importance of recording their experience in some detail in a clinical record, but I find that there is still much to be said. There is a considerable amount of drudgery to the preparation of a record, with the result that much is omitted which is later found to be important, either in staff meeting or possibly even in the court room. At one hospital there had occurred a number of instances of complicated convalescence following operation. The staff had some suspicion that it might be due to the glucose, either the solution itself or the method of its administration. One staff member was appointed to make a study of this matter for report to the staff. To his dismay and theirs he found only a few records with sufficient recorded detail to assist him. That staff now requires certain details to be recorded in such instances so that subsequent study can be made valuable. The staff as a group in setting their minimum standard cannot give too much attention to the contents of their clinical records.

The history and physical examination are important in the clinical record, but what is most important, to my mind, is the clinician's summary indicating his thinking in reaching his conclusion as to the disease process present. Too frequently this is omitted in favor of a simple statement of the tentative diagnosis, making one wonder if he might be afraid to indicate his method of arriving at the conclusion. Next most important is an accurate detailed description of the therapy used—medical, surgical, dietary or other—and the day-to-day record in the progress notes of the convalescence. A comment is needed as to the speed at which glucose solution is given or an explanation of a sudden rise in temperature. In this connection, I would banish such words as "uneventful" and "better" for more descriptive terms.

At this point the hospital administration has the responsibility of building the staff library of current experience into something worth while by making provision to index and file all records so that they are readily available for patients as a health record or for physicians as a study of illness. This requires the use of a nomenclature by both the hospital and the staff in order to index by disease classification. It also requires that the staff set forth the events in their hospital practice they may later want to study so that these can be indexed. Hospitals giving such attention to recording and indexing the experience of the staff are building a reference library of their own clinical material. Medical staffs using their clinical records as a basis for study are pooling their recorded experience. They are certainly teaching hospitals.

Frequently the discussion of medical records suggests to the staff a need for securing outside experience to add to their own. In such instances the staff will go to its medical

library to obtain the benefit of the experience of others. A teaching hospital will therefore give considerable attention to the development of the hospital library, basing it on standard texts and developing it with current periodicals. But more than just buying books and periodicals is necessary to get the fullest use of the library. In one hospital the staff requests the library committee to report at each meeting on the material received in the current periodicals. With the presentation of each clinical record some report will be made of the experience of others as recorded in the current periodicals. In other hospital there is an active journal club where each month a different phase of medical work is discussed on the basis of current and past literature. At this same hospital fifteen minutes of each staff meeting is given over to the discussion of a case record reported and discussed in one of their weekly periodicals. This case record is typed off so that each staff member has a copy. In the course of the meeting each one sums up the case history in his own words and draws his conclusion. When all have entered their comments, the final diagnosis and the comments of the attending physician are presented as well as the findings at autopsy if a death occurred. These hospitals are teaching hospitals. They are adding the proven experience of medical history to their own.

The hospitals which we are discussing will supply as complete a service in pathology as is possible under their circumstances. At a very minimum such service should be available for the examination of all tissues removed at operation or autopsy. A more complete service includes regular visits by the pathologist to the hospital, examination of all tissues removed, performance of autopsies and attendance at staff meetings. Staff members must plan to use such service as is available to its fullest extent. At one hospital only the minimum service can be provided. Here one of the local staff members is designated as laboratory supervisor with the responsibility for making the laboratory work more serviceable to the staff, for performing all autopsies, and interpreting all pathological reports. This supervisor sends a full report of his gross examination of all tissues to the pathologist so that all factors may be considered in the pathologist's report of the microscopic examination. Another hospital has been able to arrange for the pathologist to attend staff meetings. There ten to fifteen minutes of each staff meeting are given over to a clinical pathological conference using the tissues removed during the month and any available autopsy material as the basis of discussion. The staffs of these hospitals have taken as their ideal the willingness of members to review their clinical judgment objectively with the assistance of the pathologist's report and to face their clinical results at the autopsy table. The hospitals are teaching hospitals.

I have referred before to a staff meeting program devoted largely to a review of the preceding month's clinical work in the hospital. In certain hospitals with which I am familiar this consists of the presentation and discussion of all the records of illness resulting fatally, plus a discussion of records of illness in which there has been difficulty in reaching a satisfactory diagnosis or method of treatment. A report of the discussion of each individual record is recorded in the minutes of the staff meeting and a copy attached to the clinical record. In others a special report covering the clinical records of all discharged patients is considered, and certain records, selected by a staff committee, discussed. The special report presents various phases of the professional activities in terms of percents which in many ways are indices of the quality of medical work. Time will permit me to mention only a few of these percentages. There are percentage figures indicating the patients who following admission to the hospital received the minimum standard of diagnostic study as set up by the staff. In the hospital given over to the teaching of undergraduates the chief of staff views each clinical record and calls attention to those in which the diagnostic study is inadequate; but, in the small community hospital such as we are discussing, the staff as a group can form a body of opinion which will do the same thing. There is a percentage figure used in the hospitals we are discussing indicating the number of recorded consultations. The percentage of consultations should reach an absolute minimum of 15 per cent, and 25 per cent is much better. There

are percentages indicating the experience of staff members with operative therapy in terms of postoperative shock, postoperative infection, and other complications. Figures showing this experience always receive considerable attention, and provision is frequently made to study the clinical records involved. One hospital staff noted the appearance of a high percentage of postoperative infections and promptly made a study of their clinical records. The infections were found to occur whenever dependence was placed on a certain antiseptic solution. Another antiseptic solution was used thereafter with a prompt lowering of the percentage of postoperative infection. A percentage report of this type suggests to an alert staff the phase of activity requiring particular attention. A hospital in which the staff is active in reviewing their work is a teaching hospital.

In presenting the above to you as the fundamentals of a teaching hospital, I have given no attention to the subject of institutes held at the hospital under the leadership of prominent educators, of consultant staff development and use of actual postgraduate medical education undertaken by staff members at medical centers. I have also given no attention to the subject of the development of the special interests of individual staff members so as to make available to the staff members more specialized information or techniques. These also are elements in the development of the small community hospital as a teaching hospital but are elements which to be truly effective must be based on the fundamentals discussed above. The teaching values of a hospital depend on the willingness of the staff members as a group to pool their individual experience without reservation into a common fund of knowledge, to set up standards as a guide for their day-to-day hospital practice, to record their experience in an indexed library of clinical records, to consult freely with each other regarding individual patients, to lose no opportunity to check accurately their diagnoses and treatments, to study their recorded experiences in a constant attempt to improve their methods.

The small community hospital supplying on the community's part the facilities for well-rounded medical service, backed up by a medical staff giving whole-hearted attention to the above fundamentals is a real teaching hospital.

Discussion

Frederick T. Hill, M. D., Waterville: I have read and reread Dr. Morrison's paper. I only wish it were compulsory for all of our members to read it and then reread it. It is a most valuable contribution.

Dr. Morrison asks a question which is really a challenge. "Why cannot the small community hospital render such service as is rendered by the so-called teaching hospital?" From personal experience I firmly believe that it can,—if there is within the Staff the proper ideal of Medicine,—something of the scientific mind,—the urge to improve. Of course the teaching hospital, based on the pyramidal type of Staff organization, is quite a different proposition from the small community hospital; yet they both have the same problems of disease, the same responsibility to the sick, and both have interesting and valuable clinical material. It will vary, of course, in quantity, but the large hospital has no monopoly of this clinical material, and some of the most instructive cases will be found in these same community hospitals. Do you recall the Russell Conwell's "Acres of Diamonds"? Sometimes we may find the richest treasure right at home.

For years our medical schools and our teaching hospitals have devoted practically all of their efforts to undergraduate education. Yet this means simply four years, with a year or two more for internship,—compared to the thirty or more years after graduation when education is just as necessary if Medicine is to be kept on its proper level. By developing our small hospitals into teaching hospitals, as pointed out by Dr. Morrison, we will be making one of the best contributions to this program of Graduate Education.

One sentence in Dr. Morrison's paper deserves especial emphasis,—"A teaching hospital should be found wherever there is a patient and inquiring minds in the Staff of physicians attending the patient."

It almost seems nowadays to be the fashion to place a premium on personal inefficiency. Everyone expects to be coddled and supported in our New-Deal economic sphere and the idea has crept into Medicine. In developing any program of Graduate Education there is so much spoon-feeding. I know more or less of this is necessary but it ought to be used for the purpose of inoculation and not become an established habit. Yet hardly anyone admits to being self-taught, and after all this is the best form of instruction in that it sticks with one. Our leaders, our pioneers, were self-taught in their greatest development. Was Osler or the Mayos or Cushing spoon-fed? They, and the other great leaders, collected their own personal experiences, pooled them with those of their associates, and studied them in the light of the collected experiences of the Profession, as found in the Literature. They possessed inquiring minds. There are these same possibilities in the clinical material in our community hospitals if we would only use it.

It is in the organization of the Staff, and *especially* the Staff meeting, where this Spirit of the teaching hospital is either engendered or destroyed. "A concerted will to share experience, submerge individual personalities and establish a real give and take of critical judgment,"—again quoting Dr. Morrison. Get a Staff working together and thinking together and they will progress together. My old chief, Dr. Mosher, stated that physicians should devote at least one evening

each week to some form of group effort or study, analyzing and reviewing their collective experiences. Such meetings of a Staff go a long way toward developing this ideal of a teaching hospital. It may be difficult to attain but the efforts spent in trying will pay dividends.

Currier C. Weymouth, M. D., Farmington: Mr. Chairman and Members: It seems to me Dr. Morrison has covered this paper pretty well, and added to it are the remarks of Dr. Hill; so it doesn't leave much for me to say other than from a personal standpoint.

It is our good fortune to have one of these rural hospitals as established by the Commonwealth Fund in our community, that being in Farmington. We are so located that we draw from a large area, and pretty thinly settled. We draw from fifty miles and often more, and going beyond the Canadian line for some of our patients.

We have all types of work. The number of men we have in our community is limited. So we all have to be more or less specialists in our lines, so to speak, because of the type of patient brought to us.

Going back over a period of years previous, perhaps, to the establishment of this hospital in this community, I think the type of practice at present has changed greatly in this particular locality, partly from the standpoint of laboratory work and research work on patients.

At this time, or previous to this hospital being built, it was not my good fortune to be in Maine. I am a Maine product, as most everybody has claimed here this afternoon, but for a period of thirteen years during the time this hospital was being built, I was practicing in Massachusetts. Seven years ago I came back to Maine.

I had some idea of the type of practice in medicine in the locality of Farmington, because that is my native county. I was very much amazed as to what the men in and about Farmington were doing in the practice of medicine. I will have to pay them a very fine compliment in comparing them to the men practicing medicine in Massachusetts in communities much more thickly settled, from which they could get consultation work much easier than we could in Maine; I will have to say that they were very much up on their toes. They were doing most excellent work.

I think that laboratory work previous to this hospital was so limited that patients were operated on and studied more or less, perhaps, in the dark. I don't now reflect upon the learning or the teaching of these men who were practicing at that time, but I think because of the fact that the practice of medicine has changed so much, that they will be complimented in keeping up to what they have done.

In going back to the hospital and applying it in the teaching sense, I will say that we have several meetings, as outlined by Dr. Morrison, and I think in good part comply with the wishes and the requirements or suggestions as set up by the Commonwealth Fund. There is collaboration, certainly, here; all possible cases are taken up and discussed, the why's and wherefore's of the cases are brought out, one man is called to task because he did this or didn't do that. It is very important that this be done. There shouldn't be any cause for feeling among men because a man is taken to task for not doing this or that. It is the patient that is concerned. It is the outcome of that patient that we should all be interested in.

We have our system of filing and the gathering of our material from records to get a better understanding from one case to another as it may be applied.

This brings up the question of consultation as Dr. Morrison and Dr. Hill have talked about. I think in Dr. Morrison's paper there are several instances where he has alluded to our particular hospital in various things that we have found out as a teaching hospital, in pooling our knowledge.

It is not uncommon in our hospital to have a case come to the hospital, and have as high as eight or ten doctors in consultation on that particular case. There is a feeling among the men that they want to know what the other fellow knows. I don't think it is belittling to anybody to seek the other fellow's advice. It is the "Why this" and the "Why that" that makes it an interesting consultation, and we all benefit by such.

I spoke a moment ago about the limited number of doctors that we have. Competition, it is true, is a good thing. But we haven't a whole lot of competition up in our community. Perhaps we have all the doctors we need, but there isn't much room for more. This brings about one thing that looks or appears to be a possibility in the future. And I shall be very interested to have Dr. Morrison make some remarks about it if he sees fit.

I do not say that the older men haven't been trained; they are just as experienced, keen, and alert, perhaps, as the younger men; but perhaps because of the teaching system, there is a difference in the views of the older men and the younger men of today.

That brings me to the point that I wanted to bring out, and that is, special training, where there is a limited number of men. There seems to be a growing feeling in our community for specially trained men, not specializing, but specially trained. That takes in the give-and-take idea that one doctor may be better qualified to treat a certain type of case, perhaps diabetes, or in X-ray, or in fracture work, or neurology, or what-not.

What I mean to bring out is this: Wouldn't it be all to the advantage of a community to specially train certain individuals in certain lines, even though they are to continue in general practice of medicine? I would like to have Dr. Morrison's reaction to that.

I would like to add one thing about our doctors in our community. I think practically every one of them has had a fellowship somewhere or other. Some of them have been twice. Others are going, and from these fellowships they bring back knowledge to the rest of us. I thank you.

Doctor Morrison: There are two things that Dr. Weymouth mentioned. He referred to the question of special interest, and that is something in which I happen to be very much interested. I can talk for another hour on that particular subject alone because I think that with the development of these rural hospitals to be teaching hospitals, with the staff working together, there should occur the development of specialties for the several members; the staff as a group accepting or appointing or naming or instructing one member to get more information along one subject than another, according to his interest and according to the interests of the staff. This would be in line towards developing the hospital very much as a clinic, and it would be developing it as a clinic under the horizontal type of staff organization where there is no chief of staff, but a group working together. I think this sort of development is the proper method for the further growth of a teaching hospital.

There is one other thing Dr. Weymouth mentioned, namely, that the hospital in Farmington was established through the Commonwealth Fund. It was not. The Commonwealth Fund has merely assisted. The hospital was established by the people of that community and the physicians of that community. It is the kind of hospital it is because of the physicians of that community. If the Commonwealth Fund has been of any assistance, that is fine; but it is such a hospital because it is backed up by staff members such as Dr. Weymouth, Dr. Pratt, Dr. Nichols, and Dr. Bell. Thank you.

*Bleeding During Pregnancy**

By Charles P. Sheldon, M. D., Boston, Massachusetts

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Antepartum hemorrhage still remains a major complication of obstetrics. Until we know how to prevent abnormalities of the trophoblast such as hydatidiform mole and chorioepithelioma; to ensure implantation of the ovum within the uterine cavity; to limit growth of the placenta to the corpus of the uterus; to obviate premature detachment of the ovum; and prevent rupture of the uterine substance, we must be constantly prepared to deal with the problems of accidental hemorrhage during pregnancy.

Something is known of the action of uterine musculature. The muscle fibres are so arranged that they shut off the uterine sinuses when the organ is contracted. If the uterus becomes dilated the sinuses open and bleeding occurs. Hormonological investigations reveal the importance of biological checks on uterine activity. Estrin stimulates uterine motility while Progestin brings about uterine relaxation. An extract of the posterior pituitary causes increased contractility and retractility of the uterus. An alkaloid of ergot, Ergonovine, has a prolonged effect, as contrasted to the shorter action of pituitary extract. In spite of these pharmacologic and biologic contributions, accidental hemorrhage still taxes the ingenuity of the attending physician.

During the past 22 years the incidence of antepartum hemorrhage at the Boston Lying-in Hospital was one in every 30 deliveries.

Bleeding from the genital tract during pregnancy must always be considered serious unless proved to the contrary. A differential diagnosis should include those causes of bleeding which are not directly related to the pregnancy, i. e., polyps of the uterus, cervical erosion, carcinoma, fibroids, and ruptured varices. The patient occasionally mistakes rectal bleeding for vaginal hemorrhage.

Bleeding During Early Pregnancy

During the first half of pregnancy abortion or miscarriage, extra-uterine pregnancy and hydatidiform mole are the most important causes of hemorrhage in the order given.

Abortion and Miscarriage

It has been estimated that one pregnancy out of every five terminates before the twenty-eighth week. Although it is impossible to arrive at an accurate figure, Taussig[1] believes there are 700,000 abortions in the United States annually. The Children's Bureau of the United States Government[2] estimates that 50 per cent of all abortions are criminal, 37 per cent are spontaneous, and 13 per cent are therapeutic. It is impossible to justly interpret the wastage of human lives; the money spent on hospitalization; the time lost from employment, or the serious physical defects and mental stigmata which accompany abortion. It is thought[3], however, that approximately 25 per cent of maternal deaths result from abortion or its sequelæ. Attempts to impress upon the public the dangers associated with criminally induced abortion have had little effect on its incidence. An improvement of the economic situation so that women have greater inducement to rear a family might be a procedure of some value in attacking the problem.

Abortions can, for practical purposes of treatment, be divided into two groups: (A) spontaneous, afebrile; and (B) febrile or induced. Patients falling into group A may be safely curetted if the abortion seems inevitable, i. e., in the presence of uterine contractions and bleeding in excess of a normal menstrual period. Patients in group B should never be subjected to operative interference unless hemorrhage forces the issue,

* Read before the Kennebec County Medical Society, Togus, Maine, May 18, 1939.

under which circumstances digital curettage or curettage with blunt instruments are preferable to the use of the sharp curette. The latter is particularly dangerous in the presence of infection due to the hemolytic streptococcus, as it breaks down the natural protective barrier which tends to prevent spread of the infectious process into the general circulation.

A note of warning should be raised concerning the use of anesthesia for curettage of patients in poor condition. Morphine and scopolamine narcosis will suffice provided the patient is comfortably placed on the operating table in the left Sim's position. Anesthesia apparently causes uterine relaxation, increases the hemorrhage and adds to the shock. Most patients who have bled excessively have already had sufficient labor to bring about softening and some dilatation of the cervix. The small amount of hemorrhage when curettage is performed without anesthesia is always impressive. Perhaps this factor explains why the so-called professional abortionists "get away with murder."

Bed rest is still the most important therapeutic measure in the treatment of threatened abortion. We have not yet properly evaluated the value of wheat germ oil and Progestin. The former should be administered in large doses during the course of the acute symptoms[4]. The latter experimentally produces relaxation of the uterine musculature and, therefore, should allow the hemorrhagic process in the decidual basalis to become quiescent. The degree of placental separation already present determines the future course of events. If the ovum is already dead no therapeutic measure will be of avail and the embryo will either be cast off or will be retained in utero as a missed abortion.

Extra-Uterine Pregnancy

The differential diagnosis between threatened uterine abortion and tubal pregnancy is often exceedingly difficult, particularly before the stage of tubal rupture. Extra-uterine pregnancy is usually characterized by less extensive genital hemorrhage and greater abdominal discomfort and pelvic tenderness than uterine abortion. A tender boggy mass in one vault suggests tubal pregnancy but may be confused with a small ovarian cyst or the corpus luteum of pregnancy. Early uterine pregnancies are sometimes embedded in one cornu of the uterus and simulate extra-uterine implantation. The diagnosis after tubal rupture is usually quite easy. The patient has evidence of concealed intra-abdominal hemorrhage (pallor, rapid pulse, low blood pressure, abdominal tenderness and high white count) plus pelvic tenderness, a mass in one vault and a doughy sensation in the posterior cul-de-sac due to the pelvic hematocoele.

Abdominal pregnancies are always secondary to tubal abortion or rupture. They are diagnosed at bimanual examination by finding a pregnancy in the abdominal cavity in the presence of a uterus which is only slightly enlarged. The fetus is readily palpable beneath the anterior abdominal wall. It is usually in an abnormal attitude, high in the abdomen and very often dead or malformed.

The treatment of tubal pregnancy is surgical extirpation of the affected tube. Hysterectomy is sometimes indicated when the interstitial part of the tube is involved. Transfusion, using blood either from the patient's peritoneal cavity (autotransfusion)[5] or from a suitable donor, is often a life-saving procedure.

Patients with a known abdominal pregnancy in which the fetus is dead should not be operated upon until one month has elapsed following fetal death. This facilitates separation of the placental attachment at laparotomy. If the child is known to be alive operation should not be delayed. The secundines are left within the abdomen if they are firmly adherent to vital structures (bowel, mesentery, bladder, etc.). If the placenta is attached only to the uterus and broad ligament, hysterectomy is indicated. In the presence of infection or potential infection, marsupulization of the sac is the procedure of choice provided a hysterectomy cannot be safely performed. The embryonic tissue will eventually slough out of the wound.

Hydatidiform Mole

Hertig[6] estimates that cystic degeneration of the chorionic villi occurs in approximately 50 per cent of the cases of spontaneous abortion. True hydatid mole formation has occurred once in every 1,736 deliveries at the Boston Lying-in Hospital since January 1, 1916. It is usually characterized by serious vaginal bleeding, rapid growth of the uterus, absence of fetal outline by X-ray examination, and a strongly positive Ascheim-Zondek test. The latter is a result of the high concentration of gonadotrophic hormone which produces a luteinizing effect on the ovary of immature mice. The presence of translucent vesicles in the vaginal discharge or finding them at curettage establishes a positive diagnosis.

As in premature termination of normal intra-uterine pregnancy the chief factor which determines the method for emptying the uterus is the condition of the cervix. If soft, taken up and partially dilated or dilatable the procedure of choice is curettage, preferably without anesthesia. In the face of an unfavorable cervix or a uterus larger than a four months' pregnancy, abdominal hysterotomy is a safer procedure than curettage.

Since about 5 to 10 per cent of hydatid moles subsequently lead to chorio-carcinoma the patient must be under careful observation for at least two years. Ascheim-Zondek tests should be performed at monthly intervals during the first year. Another curettage is indicated in the presence of recurrent hemorrhage. Hysterectomy and bilateral salpingo-oophorectomy are indicated if chorio-carcinoma develops.

Bleeding During the Last Half of Pregnancy

Since most miscarriages (termination of pregnancy from the sixteenth to the twenty-eighth week of gestation) are in their genesis due to hemorrhage in the decidua basalis they are in reality cases of premature separation of the placenta. As placenta previa can occur at any time following formation of a definite placenta (about the fourth month) some miscarriages are fundamentally premature separation of a low attached placenta.

Premature Separation of the Normally Implanted Placenta

Premature separation of the normally implanted placenta is the commonest of all obstetrical emergencies. It has occurred once in every 90 deliveries at the Boston Lying-in Hospital since January 1, 1916[7].

Toxemia is the most important predisposing cause of premature separation. Forty-three and three-tenths per cent of 407 cases had either hypertension, albuminuria or both. Since many of the severe cases of uteroplacental apoplexy of Couvelaire have an associated toxemia, some obstetricians have felt that there must be a specific toxic element which leads to extravasation of blood and dissociation of the uterine muscle fibers by blood and edema.

The signs and symptoms of premature separation vary with the duration and extent of the process and the degree of concealment of the hemorrhage. Many patients with internal hemorrhage do not consult a physician until the bleeding appears externally. By this time the loss of blood is often excessive and the patient's life in grave danger. On the other hand, some patients have localized areas of separation which are self-limited and often undiagnosed. If hemorrhage is external it is usually severe. Pain is a variable symptom but may be marked if the uterus becomes distended with retained blood. Under these conditions the visceral peritoneum becomes stretched and may actually tear. The uterine musculature, when infiltrated with blood, becomes spastic. This rigidity persists unless the hemorrhage is excessive and prolonged when the organ loses its powers of contractility and retractility and becomes dilated, atonic and flabby.

Accouchement forcé has been discarded by most obstetricians in the treatment of premature separation since it increases the shock and hemorrhage from which these patients are already suffering. Cesarean section has been advocated as a means for bringing about immediate delivery but it, too, is often productive of shock and increased hemorrhage. Polak, in 1931[8], introduced into this country a modification of the Dublin technique for treatment of premature separation. His method has been used at the Boston

Lying-in Hospital with excellent results. Maternal mortality has dropped from 14.5 per cent for cesarean section to 2.9 per cent for conservative measures in the treatment of patients with internal hemorrhage[9].

In general, treatment varies according to the stage of pregnancy, condition of the cervix, and condition of the mother and child. Patients already in labor are delivered from below unless there is some contraindication to pelvic delivery. A few such patients are delivered by cesarean section for the sake of the baby. Those who are allowed to proceed in labor frequently have the membranes artificially ruptured since this procedure often checks the hemorrhage. Occasionally labor is hastened by small injections of posterior pituitary extract or by the insertion of a Vorhees bag. Patients with internal hemorrhage should be delivered by that method which is least productive of shock under the existing circumstances. The baby is usually dead and needs no consideration. If the cervix is unfavorable or there is some other contraindication to pelvic delivery (cephalopelvic disproportion, previous cesarean section, fibroids, etc.), cesarean section may be the procedure of choice and should be followed by hysterectomy if the uterine musculature is so infiltrated with blood and edema that it no longer will contract and control the hemorrhage. Most cases, however, will have sufficient softening and dilation of the cervix to allow the insertion of a gauze pack into the lower uterine segment, cervix and vagina. The membranes should first be ruptured to allow the escape of amniotic fluid so that the uterus can contract down around the baby. The latter combines with the pack to act as a tamponade of the generative tract. A tight abdominal binder prevents the uterus from becoming distended with blood. Pitocin (posterior pituitary extract without the pressor effect) in divided doses will stimulate labor and bring about delivery. The uterus should be tightly packed with gauze if postpartum bleeding is excessive. The Holmes packer[10] is a valuable instrument for tamponade as it insures packing from the top of the fundus downward and diminishes the chances for uterine infection. If hemorrhage persists in spite of pituitrin, ergot, massage and packing nothing remains but to amputate the uterus. Transfusion should be employed freely. Anuria is an ever-present danger which follows cesarean section and hysterectomy much more commonly than pelvic delivery.

Placenta Previa

Placenta previa has occurred once in every 100 deliveries at the Boston Lying-in Hospital. The exact cause of implantation of the placenta in the lower uterine segment is unknown, although multiparity seems to have a definite effect. The relationship of the placenta to the internal os explains the sudden, painless bleeding as contrasted to the concealed, painful hemorrhage so often seen in premature separation of the normally implanted placenta. The blood finds a ready exit in placenta previa so that the patient's general condition is commensurate with the amount of blood lost. There is a high incidence of fetal malpresentation and malposition due to the fact that the presenting part is held out of the pelvis by the placenta. The baby is usually alive, even though immature. A soft-tissue roentgenogram following injection of a contrast dye into the bladder may show a shadow between the bladder and the presenting part if the placenta is implanted in this region[11]. Vaginal examination discloses the placenta in contact with or covering varying degrees of the internal os.

Every patient with antepartum hemorrhage in the last half of pregnancy should be considered a case of placenta previa until proved otherwise. Once the diagnosis is established treatment varies according to the degree of previa, the viability and condition of the child, the general condition of the mother, and the potentialities for infection. When the baby is alive, viable, and in good condition cesarean section ensures the infant an 85 per cent chance for survival[12]. If the mother is in good condition and not contaminated by improperly performed vaginal examinations or tamponade her risk from cesarean section is approximately 5 per cent. Most cases with marginal previa respond to simple rupture of the membranes. If the baby is dead, non-viable or deformed, or if the mother is in poor condition, Braxton

Hicks version is the procedure of choice provided the cervix is dilated two finger-breaths[13]. If the cervix is undilated a Vorhees bag inserted intraovularly will bring about partial dilatation, following which a Braxton Hicks version can be performed. Forceful traction should never be exerted during delivery of the fetus as the lower uterine segment is soft and tears easily. Craniotomy is of value for delivery of the after-coming head. Infected cases should be delivered by Porro hysterectomy, supplemented by abdominal and vaginal drainage, regardless of the condition of the baby or the parity of the mother.

Patients with suspected previa should never be examined pelvically for the purpose of diagnosis unless they are prepared for immediate delivery. The operating room should be set up with two separate tables. One table should contain equipment for bagging or Braxton Hicks version; the other should be available for laparotomy. The patient should be examined under anesthesia. If a central or partial previa is encountered immediate cesarean section can be performed which ensures against extensive blood loss. The classical incision avoids the sinuses in the lower segment. Tamponade is occasionally necessary for the control of postpartum hemorrhage. Hysterectomy is rarely indicated except in infected cases.

Rupture of the Uterus

There were 33 cases of rupture of the uterus treated at the Boston Lying-in Hospital between January 1, 1916, and January 1, 1938, an incidence of one in every 1,105 deliveries. Eighteen were traumatic and 14 were spontaneous. The incidence of rupture is increased by the injudicious use of pituitary extract during labor; manual dilatation of the cervix; internal podalic version; and the increasing frequency of cesarean section.

An outstanding factor in the etiology of traumatic rupture is multiparity. Obesity, large babies, and perhaps other factors predispose to abnormalities of presentation and position. Uterine inertia and cervical dystocia are more common than in primiparæ.

The sequence of events in the development of traumatic rupture may be quite characteristic. Because of prolonged labor, fetal distress, or demands for relief from either the patient or her relatives, the physician feels obligated to bring about delivery under unfavorable circumstances. He accordingly manually dilates the cervix and applies high forceps. Forceps failing, he attempts internal podalic version. Due to prolonged rupture of the membranes with escape of amniotic fluid, spasticity from prolongation of the labor, or irritability set up by repeated attempts at delivery, the uterine musculature does not relax sufficiently for the baby to be turned easily. Rupture occurs in the thinned out lower uterine segment.

Since repeated attempts at delivery make the uterine musculature increasingly spastic, craniotomy and high forceps should not be attempted if there is reasonable doubt of their success. If the operator feels that he can safely deliver the patient by internal podalic version he should proceed with this procedure forthwith. Full surgical anesthesia with open ether is the anesthesia of choice. If the uterus cannot be relaxed under anesthesia version should be abandoned and the patient should be delivered either by an extra-peritoneal cesarean section or by Porro hysterectomy.

Cesarean section is the most important predisposing cause of spontaneous rupture of the uterus. Twenty-seven and three-tenths per cent of all ruptures of the uterus treated at the Boston Lying-in Hospital followed a previous cesarean operation, illustrating that this is not "just another way to have a baby." It was the predisposing factor in 64.3 per cent of the spontaneous ruptures. Fundal scars tend to rupture during pregnancy while scars in the lower uterine segment pull apart during labor. A longitudinal scar in the lower segment is subjected to less stress than a transverse scar when the lower segment begins to develop during labor.

Maternal mortality is influenced by the time interval between rupture and the institution of treatment[14]. Hysterectomy and adequate drainage of the peritoneal cavity performed within four hours of the occurrence of rupture give the best results. Expectancy has no place in the treatment of this condition. Patients with unrecognized or un-

treated ruptures die of infection if they do not succumb to hemorrhage and shock. There will be fewer unrecognized cases if the operator inserts his hand and carefully palpates the interior of the generative tract following each difficult delivery. Uterine tamponade is a valuable procedure for control of blood loss while preparations are being made for operation. Transfusion is an indispensable adjunct and may save the patient's life.

Summary and Conclusions

1. Antepartum hemorrhage should always be considered serious, whatever the stage of pregnancy, until proved otherwise.

2. Endocrine therapy offers some hope in the treatment of spontaneous abortion. Vitamin E should be tried as a prophylactic measure for those patients who habitually abort.

3. Curettage without anesthesia is made possible by narcosis with morphine and scopolamine. This is the safest procedure if the patient is in poor condition as a result of shock and hemorrhage.

4. Every patient with hemorrhage early in pregnancy should be suspected of having an extra-uterine pregnancy.

5. Abdominal hysterotomy should be employed for emptying the uterus in those cases of hydatid mole where the uterus is large or the cervix unfavorable.

6. Conservatism gives the best results in the treatment of premature separation of the normally implanted placenta.

7. Cesarean section is the procedure of choice in the treatment of placenta previa if the mother and baby are both in good condition and the mother uninfected.

8. Cesarean section should never be taken lightly. It is the most important cause of spontaneous rupture of the uterus.

9. Careful exploration of the entire generative tract following difficult deliveries will reveal traumatic ruptures of the uterus, otherwise often unsuspected.

10. Rupture of the uterus is best treated by hysterectomy.

11. Transfusion is the most important single advance in the treatment of bleeding during pregnancy.

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Teach the tuberculous patient to regard symptoms as red and green signal lights and not something to worry about.

In tuberculosis, care and personal discipline without climate are better than climate without care.—Wm. Osler.

*Endometriosis of the Vagina**

(WITH CASE REPORT)

By W. F. W. Hay, M. D., F. A. C. S., Portland, Maine

In the vagina, endometriosis is invariably found in the rectovaginal septum, and may consist of only a few nodules which feel like bird shot, or may glue the posterior aspect of the cervix to the rectum. The glands are usually small, but may become quite large and be filled with the typical chocolate material. Sampson, in all the cases which he studied, found that vaginal endometriosis was directly continuous with peritoneal endometriosis in the posterior cul-de-sac.

The origin of endometriosis in the rectovaginal septum is somewhat disputed. According to Sampson's theory of implantation, this must be an outgrowth of peritoneal lesions. According to the "Mullerian theory", these lesions arise from Mullerian rests.

In this case at hand, the latter theory would explain the findings more satisfactorily.

Endometriosis is a condition found between the ages of 25 and the menopause. Sterility is a common complaint, Sampson finding 70% of his cases sterile, and, of the remaining cases, only one had more than one child. Dysmenorrhea is a common symptom, particularly of the acquired type. Because of the scarcity in pregnant cases, the effect of pregnancy on endometrial lesions is little known.

Case History: L. A., M. G. H.-50522

The patient was first seen by me on March 12, 1937. She was 25 years of age and had been married 6 months previously. Her complaints consisted of increasing dysmenorrhea over a period of two years, pain in lower abdomen, especially on the right, some leucorrhea which was getting worse, and painful intercourse. Examination was very difficult because of a very small introitus. A small mass was felt in the vagina and thought to be a cervical polyp; a speculum could not be used.

Two weeks later, the patient returned complaining of marked increase in vaginal discharge and her period overdue. Examination revealed that the polyp had doubled in size. On April 13th, she was given a little gas and an examination revealed a vagina filled with a polypoid mass which did not come from the cervix, as surmised, but from the rectovaginal septum. This mass was removed as close to its base as was thought wise, leaving a base about the size of a fifty cent piece and about 2 cm. thick. Marked bleeding was controlled by a vaginal pack. This mass, when removed, was about 2 inches long and one inch in diameter. Frozen sections, and later microscopic studies, showed this to be of endometrial origin with a marked decidual reaction. The uterus was about the size of a two months' gestation. During the next month the mass continued to grow until it was almost as large as it had been before its partial removal. At about four months it started to recede and shrunk to a mass about the size of a fifty cent piece and 1 cm. thick; attached to the septum with part of it on the rectal wall and part on the posterior wall of the cervix.

The prenatal period was uneventful and because of the probability of an endometrial growth in the posterior cul-de-sac, Caesarean section was elected. On November 16, 1937, a normal male child was delivered and a very careful examination of the adnexa and posterior cul-de-sac revealed no signs of endometriosis. The left ovary presented a corpus luteum cyst and because of a few hard nodules could be felt, this was resected. Miscoscopic studies showed no signs of endometriosis. The convalescence was uneventful and on the 12th day postoperative the patient was examined under gas and a mass about the size of a fifty cent piece and 1 cm. thick was found attached to the rectovaginal

* Read at the meeting of the New England Obstetrical and Gynecological Society, at Portland, Maine, May 24, 1939.

septum. A biopsy was taken which showed endometriosis but with the pregnancy features disappearing.

During her pregnancy the patient had been told that she was fortunate to be pregnant and that if she were to have more children, she had better become pregnant as soon as possible. She took me at my word and returned pregnant within four months after her baby was born. During the first three months, this endometrial mass grew many times its size but no tissue was removed and it gradually receded to its original size in the later months of pregnancy. The prenatal period, except for the changes in the growth, was uneventful until the eighth month, when I discovered that she had a twin pregnancy. She was very uncomfortable because of her size at the time and on November 8, 1938, three weeks before term, was delivered, by Caesarean, of male twins, weighing seven pounds ten and one-half ounces and five pounds eleven and three-fourths ounces. Thus, the day following delivery, she had three male children all under one year of age. Careful examination showed no signs of endometrial growth in the posterior cul-de-sac or adnexa. One month ago, or 5 months after her twins were delivered, the patient was examined under gas and several hard shot-like nodules were found in the rectovaginal septum and some of these were removed for biopsy. Microscopic studies showed these to be of endometrial origin.

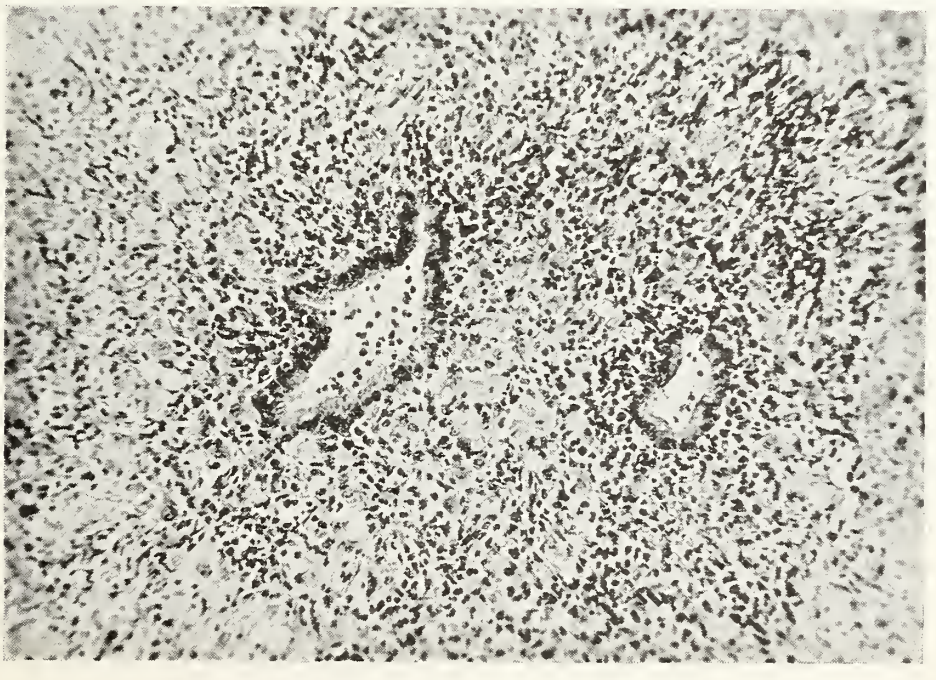
This case is interesting to me for the following reasons:

1. Not all cases of endometriosis can be explained by the implantation theory of Sampson. This case seems to be much better explained by the theory of fetal rests from the Mullerian ducts.

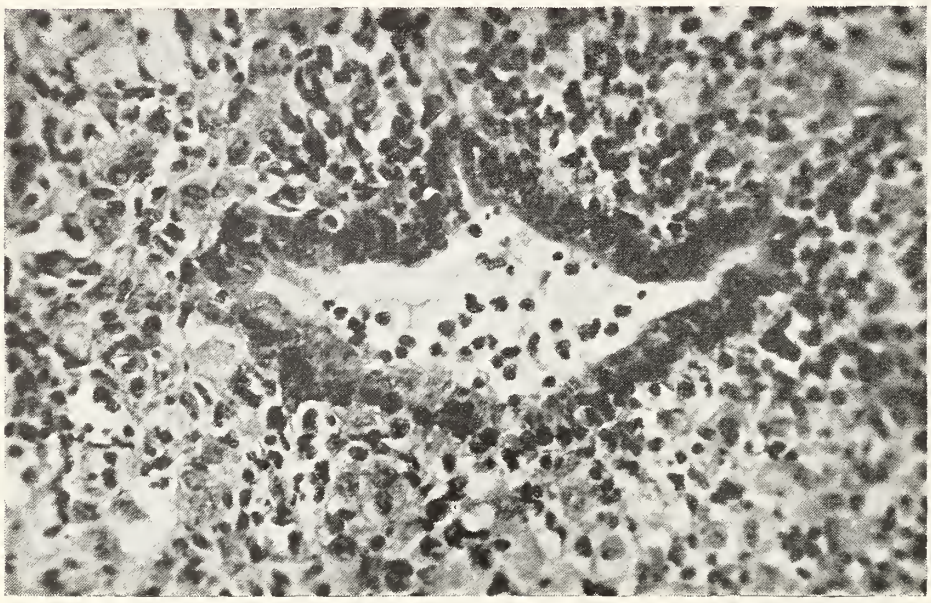
2. This case shows very clearly the marked hyperplasia of the vaginal endometrial growths during the early months of pregnancy with the marked decidual reaction and the subsequent regression of these growths after the fourth month.

3. Certainly all patients who have endometriosis are not even relatively sterile.

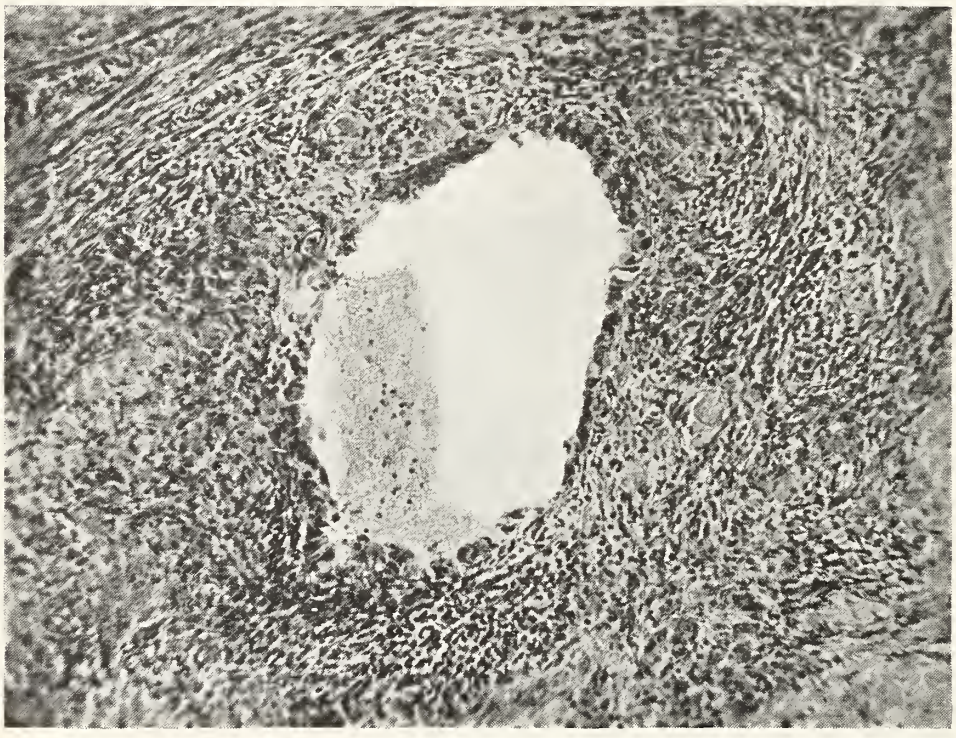
I should like to thank Doctor Warren of the Maine General Hospital, Doctor Smith of the Women's Free Hospital in Boston, and Doctor Hertig of the Boston Lying-In Hospital for their assistance in preparing the following slides.



Slide No. 1 is x 50, of the first biopsy taken April 13, 1937, when about two months pregnant. You will notice squamous epithelium of the vagina, normal vaginal stroma, and endometrial glands and decidual reaction below and to the right on this slide.



Slide No. 2, x 125 high power, is of the blocked-out area in slide No. 1.



Slide No. 4, x 50, low power, of a biopsy of the vaginal wall from the site of the endometriosis, 12 days after the Cæsarean section November 27, 1937. You will note that most of the stroma, together with the gland, shows a regression of the pregnant picture, and that only occasional decidual cells are seen.

Slide No. 6, April 16, 1939, is the recent biopsy of the vaginal wall in the region of the endometriosis and, obviously, shows nothing but surface mucosa, which is broken, together with a normal vaginal wall, and a few areas of endometrial glands.

Slide No. 6A is a high power of the same thing.

*Diabetes Innocens**

By E. R. Blaisdell, M. D., F. A. C. P., Portland, Maine

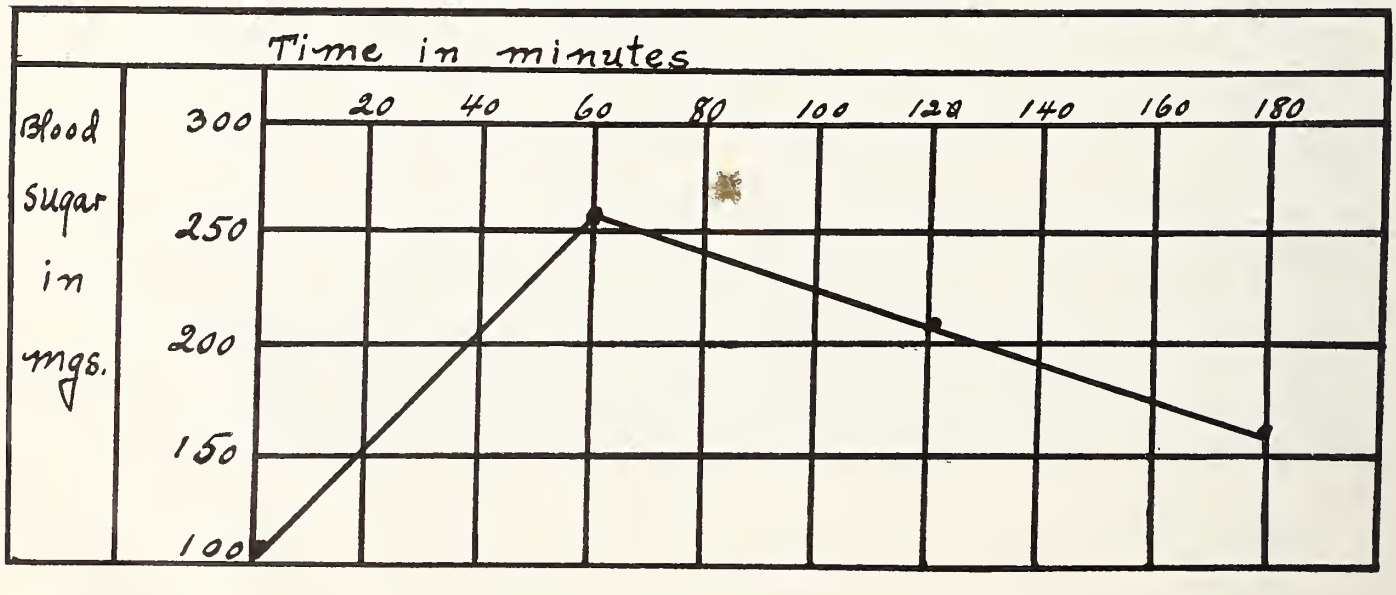
(A CASE REPORT)

A male, aged 20 years, was referred for investigation of a persistent heavy glycosuria which had failed to respond even in the slightest degree to a well-balanced diet with moderate carbohydrate restriction. Thirst, polyuria, and acidosis were absent. There was no weight loss or symptoms as a result of the urinary sugar. Sugar had been discovered in the urine one month before during a life insurance examination which was the first time that the patient had ever been examined.

One maternal uncle had been rejected for life insurance forty years ago because of a glycosuria. He is still living and well without ever having received treatment.

The past history was unimportant. Symptoms were entirely absent. Physical examination failed to reveal any pathology other than a post prandial hyperglycemia and a constant heavy glycosuria. The weight was 140 pounds and the height 66 inches. There was no evidence of pituitary or other glandular dysfunction. The retinae were normal in appearance. The heart and lungs showed no evidence of disease. The blood pressure was 120 systolic and 80 diastolic. The abdomen was negative to percussion and palpation. There were no pathological reflex changes and a later report showed the blood serology to be negative. The urine and blood sugar findings were as follows: 5 hours after breakfast, the blood sugar was 101 mg., and the urine gave a yellow reduction with Benedict's solution, the specific gravity was 1.025, and there was no albumin, no casts, nor acetone bodies. Following the ingestion of 100 grams of dextrose on an empty stomach, it will be noted that the blood sugar rose to 252 mg. in the first hour, was 225 mg. in the second hour, but three hours later had dropped to 167 mg. The urine constantly gave a yellow reduction without acetone bodies. The laboratory reported the reducing agent to be glucose. Unfortunately, the blood sugar readings were not continued after the third hour, but the hospital metabolic chart showed that the blood sugar level was constantly normal four hours after meals that contained from 70 mgs. to 100 mgs. of available carbohydrate. The patient was discharged with instructions to his family physician for a regular diet and a yearly fasting blood sugar determination.

Blood Sugar Levels Following 100 Grams of Glucose



* From the Medical Service, Maine General Hospital.

Hospital Diabetic Chart

1939		DIET (in grams)					URINE			BLOOD
Month	Day	Pro.	Fat	C H	Total Calories	Available C H gms.	Sugar Reduction	Acetone	Diacetic Acid	Sugar mg.
July	11	75	83	150	1650	198	Yellow Yellow Yellow	0 0 0	0 0 0	12.30 noon 107
July	12	75	69	200	1800	250	Yellow Yellow Yellow	0 0 0	0 0 0	12.30 noon 100
July	13	75	55	250	1800	300	Yellow Yellow Yellow	0 0 0	0 0 0	12.30 noon 105
July	14	75	55	250	1800	300	Yellow Yellow Yellow	0 0 0	0 0 0	12.30 noon 105

"Diabetes Innocens" is probably a poor name to apply to this apparently harmless and relatively rare combination of constant glycosuria with normal fasting blood sugar and post-prandial hyperglycemia. Some authors†, however, in the absence of demonstrable signs and symptoms of glandular dysfunction, have preferred this term.

Renal glycosuria, also relatively rare, is a more frequent finding. Here, following a glucose tolerance test, the blood sugar seldom goes above 140 mg., although the urine constantly shows sugar. It is extremely important to recognize both renal glycosuria and "diabetes innocens" as insulin is contraindicated in both conditions. Insulin is not only useless, but is extremely harmful. It is obvious from the accompanying chart that the blood sugar will become spontaneously normal at a time when the maximum effects of either regular or protamine insulin would be present; that is, four or five hours after a meal or in the early morning, and the administration of insulin would be followed by insulin shock. Furthermore, dietary restriction may be useless. This was demonstrated in this patient who, in spite of a restricted admission diet containing approximately 120 gms. carbohydrate, constantly excreted about the same amount of sugar as he did when receiving 250 gms. Therefore, without sufficient carbohydrate intake to balance the sugar excretion, a loss of energy and body weight would result.

† Paullin, James E.; The significance of glycosuria. Annals of Internal Medicine, 1929, 111, 137-143.

Tuberculosis Among College Students. During 1937-1938 over 64,000 students were given tuberculin tests with 25.8% showing positive reactions. Since 1932-33 when the first figures were collected there has been a steady increase in the number of tests and a slow but steady fall in the percentage of reactors. "The value of the tuberculosis program to the individual student, whether he be the patient or the protected, is incalculable," reports the Committee. "The effort of finding tuberculosis is justified by the educational value alone. It is a demonstration of how lives can be saved and the community safeguarded. This is hygiene that actually operates."—*Ann'l Rep. Tuber. Comm. of Amer. Student Health Assn.*, 1937-1938.

The President's Page

To the Members of the Maine Medical Association:

Consideration of some of the financial aspects of the Wagner Act is interesting.

In the first place it seems rather remarkable that an Administration which has been piling up huge deficits for years, until the legal debt limit of the country is approached, should now contemplate, with apparent equanimity, a new scheme which would increase Federal expenditures by hundreds of millions at once, and by billions eventually.

It seems to be fashionable nowadays in certain quarters when the cost of some desirable end is prohibitive, to proceed just the same, and issue bonds for Posterity to pay. The amount seems to be of no great consequence.

This works very well indeed. Posterity has made no objection whatever and will have to pay—unless it should come to pass that Posterity is unable to pay—or should declare that as it had not been consulted, and had had nothing to do with incurring the debts, it would wipe the slate clean by repudiation and start over again.

Possibly it might look better to devalue the dollar and accomplish repudiation in that not entirely unprecedented manner.

The Federal system of "grants in aid" to State, works somewhat as follows:

The Federal Government appropriates a sum, raised by taxation, from all the States, for some specific purpose.

The States may get some of this back by appropriating a sum which is matched by the Federal Treasury, provided the plans for expenditure are approved, in the case of the Wagner Act by the Departments of Labor, the Treasury, and the Social Security Board.

As no one likes to be taxed without getting something in return, of course the States will try to adopt plans that will meet with the approval of these Departments.

What sort of plan would the present Departments be likely to approve?

From what we know of their records and personnel, it seems probable that they would look with favor on such a plan as was presented to the New York Assembly in the Goldstein Bill, which would make the status of the Medical Profession just about that of the Police force or the mail carriers.

That is probably just what the proponents of the Wagner Act wish to bring about.

George L. Pratt, M. D.,
President, Maine Medical Association.

Editorials

Is the Chronic Appendix a Surgical Myth?

Certain writers on the subject of appendicitis deny the fact that the appendix can be the seat of chronic disease. Many clinicians, judging from their remarks, evidently hold a positive view with more or less mental reservation. If one recognizes, however, that there are two essentially different types of acute disease of the appendix, each with its own pathology and clinical picture: (1) Acute inflammation of the wall of the appendix without obstruction of the lumen; (2) Acute obstruction of the lumen, much of the confusion that seemingly exists might be replaced by an appreciation of the fact that the appendix can be and often is the seat of conditions that warrant acceptance that such a condition is a pathological and clinical fact.

Acute inflammatory disease of the appendicular wall is of very common occurrence, and the milder types often occur and subside without a physician being called. The disturbance may be transitory, is usually attributed to some dietary indiscretion, and many times the attacks are forgotten by the patient or assumed as of little or no significance in a clinical resumé. If a given attack does subside (some do quite completely and some with more or less residual tenderness for a few days), the important fact to bear in mind is that a restitution to normal may not occur and the resulting pathological legacy may be an angulated, stenosed or bound down appendix, with or without fecal concretions, that may make the life of the patient more or less miserable by attacks of recurrent pain; reflex gastric, intestinal and biliary upsets, but what is most significant, and always to be borne in mind, an appendix so involved is especially vulnerable and is most liable to an attack of the obstructive type. Accepting this clinical fact, it is extremely well to recall that as an anatomical fact the appendix is a blind end diverticulum of the large gut and that obstruction of its lumen from any cause, with resulting retention of its extremely septic contents — and the virulence increases rapidly once obstruction is a fact — demands the same meticulous care in establishing a prompt diagnosis and the same promptitude for operation as is demanded in obstruction in any other segment of the intestinal tract.

The challenge of the extremely high death rate resulting from peritonitis following rupture must be met. Obviously, septic peritonitis would not be a complication or an end result if the diagnosis is made before the "blow out" and proper treatment employed. It reflects poorly on our common sense to deny as a clinical fact what, so many, many times, is disclosed in living pathology at operation. The careful and shrewd clinician can obtain a great deal of valuable information in establishing a diagnosis by obtaining from a given patient the story, which if interpreted correctly, points to previous attacks of the non-obstructive type of the disease. To deny that the appendix can be and many times is the seat of chronic disease is, in the popular parlance of the day, "leading with your chin."

The Fall Clinical Session

The Fall Clinical Session will be held in Waterville Wednesday and Thursday, October 25th and 26th. Originally this meeting was scheduled to be held at Bangor but due to delays beyond the control of contractors and the hospital staff it was found that it would be impossible to proceed as planned. The clinicians and hospitals of Waterville most kindly stepped into the breach and since we can recall with pleasure and profit the meeting that was held there a few years ago those attending can anticipate a like program this year.

The program for each day will be divided into clinics, case reports and demonstrations with a diversity that offers those interested in special topics a fine selection. The program for Wednesday evening will be a Panel on

Anesthesia, a subject of great importance to those on hospital staffs and general practice, and the list of speakers guarantees that this symposium will be well worth while. Anesthesia today has become one of the recognized fields of specialized medicine. As a member of the operating team the competent anesthetist assures far more than the patient will be unconscious. Thursday evening the program will be under the auspices of the Kennebec County Medical Society and the speaker of the evening will be Dr. Elliot Joslin, who needs no introduction to a Maine audience or one elsewhere. As a teacher and practitioner Dr. Joslin stands pre-eminent in his field of work and we are fortunate indeed to be able to have him with us.

Evening Programs of the Fall Clinical Session

The evening programs of the Fall Clinical Session having been delegated to the Committee on Graduate Education, this committee considered what subjects would be most valuable. The committee was unanimous in selecting "Modern Anaesthesia" as a subject for the first evening's program. It was realized that there was a great need for education along this line. Anesthesia has at last come into its own. No longer is it just a case of "getting someone to pour ether." The importance of the anaesthetic state, both to the patient and to the surgeon, is at last getting the recognition that it should. We, in Maine, are still far behind Times in this respect and are in need of considerable reformation. The committee decided upon a Panel Discussion upon this subject and has invited some of the best authorities in this country to participate.

Dr. Howard M. Clute, Professor of Surgery at Boston University, will discuss the subject from the viewpoint of the surgeon. Dr. M. Fletcher Eades, one of the younger obstetricians connected with the Lying-in Hospital, will discuss the subject, taking up the question of anaesthesia and analgesia in obstetrics. Dr. Sidney C. Wiggin of Boston, anaesthetist at the Faulkner Hospital and instructor in Anaesthesia at the Harvard Medical School, will discuss anaesthesia in its present-day application. Dr. Gilbert Clapperton, anaesthetist at the Central Maine General Hospital, will speak upon the subject from the viewpoint of the small general hospital. Dr. Paluel J. Flagg of New York, President of the Society for the Prevention of Asphyxial Death, will discuss Endotracheal Anaesthesia and Asphyxia, and will summarize the whole discussion. He will use moving pictures in his presentation. Dr. Flagg is an outstanding authority on his subject and it will be a great privilege to have him with us.

The second evening's program will be under the auspices of the Kennebec County Medical Society, who have as their speaker Dr. Elliot C. Joslin of Boston. Dr. Joslin is so well known as an authority on Diabetes that no further information is required. Both of these evening programs should prove extremely interesting and instructive and mark an epoch in our program of Graduate Education.

An invitation has been extended through the Maine Hospital Association to all hospital superintendents and operating room superintendents to attend the meeting Wednesday evening on Anaesthesia.

PROGRAM

FALL CLINICAL SESSION

Waterville, Maine

Wednesday and Thursday

October 25, 26, 1939

Headquarters and Registration

ELMWOOD HOTEL

Clinics at

CENTRAL MAINE SANATORIUM

ELM CITY HOSPITAL

SISTERS HOSPITAL

THAYER HOSPITAL

SEE FOLLOWING PAGES FOR PROGRAM

Wednesday, October 25th

9.30 A. M.	11.00 A. M.	2.00 P. M.	3.30 P. M.
Sisters' Hospital Dr. E. W. Paine "Burns"	*Thayer Hospital* Dr. A. H. McQuillan "Skin Grafts"	*Thayer Hospital* Dr. E. H. Risley "Cancer of Rectum"	*Elm City Hospital* Dr. J. G. Towne "Medico-legal Problems"
Thayer Hospital Dr. R. L. Reynolds Gynecology— "Post-Menopausal Bleeding"	*Elm City Hospital* Dr. H. B. Bourassa Operative Clinic	*Sisters' Hospital* Dr. B. O. Goodrich "Sulphapyridine in Pneumonia"	*Sisters' Hospital* Dr. A. Cook "Hychonephrosis"
Sisters' Hospital Dr. Leo Brett Orthopedic Clinic "Management of Fractures"		*Thayer Hospital* Dr. C. S. Bauman "Childhood Diets— The Child Who Will Not Eat"	*Thayer Hospital* Dr. W. L. Gousse "Fractures in the Aged"
Sanatorium Dr. George Young Dry Clinic "Differential Diagnosis"	*Sanatorium* Dr. C. D. Cromwell Dry Clinic "Progress in Treatment of Tuberculosis"	*Sanatorium* Dr. George Howard "Pneumothorax— Results—Indications for Further Treatment"	*Sanatorium* Ward Rounds
Thayer Hospital Dr. J. O. Piper "Value of Laboratory Procedures in Diagnosis"	*Thayer Hospital* Dr. T. E. Hardy "Pneumonia"	*Sisters' Hospital* Dr. M. Lubell, et als. "X-Ray Therapy"	
Thayer Hospital Dr. H. F. Hill Operative Clinic Ophthalmology		*Elm City Hospital* Dr. C. E. Towne Dry Clinic Gynecology	*Thayer Hospital* Dr. F. R. Carter "Syphilis of Central Nervous System"
Elm City Hospital Dr. T. C. McCoy Operative Clinic "Local Tonsillectomy"	*Sisters' Hospital* Dr. V. C. Totman Operative Clinic "Tonsillectomy"	*Thayer Hospital* Dr. F. T. Hill "Local Anæsthesia in Oto-laryngology"	*Thayer Hospital* Dr. E. R. Irgens Dry Clinic "Nasal Plastics"

Wednesday Evening

6.30 P. M.—Dinner, Elmwood Hotel.

8.00 P. M.—Program—under the auspices of the Committee on Graduate Education. Panel Discussion—"Modern Anæsthesia."

Frederick T. Hill, M. D., *Chairman*
Howard M. Clute, M. D., Boston, Massachusetts
M. Fletcher Eades, M. D., Boston, Massachusetts
Sidney C. Wiggin, M. D., Boston, Massachusetts
Gilbert Clapperton, M. D., Lewiston, Maine
Paluel J. Flagg, M. D., New York City

Thursday, October 26th

9.30 A. M.	11.00 A. M.	2.00 P. M.	3.30 P. M.
Elm City Hospital Dr. J. G. Towne Operative Clinic	*Elm City Hospital* Dr. A. W. Moore Psychiatry "Melancholia"	*Sisters' Hospital* Dr. L. A. Guite "Head Injuries"	*Sisters' Hospital* Dr. O. F. Pomerleau "Common Duct Stones"
Thayer Hospital Dr. A. H. McQuillan "Spontaneous Rupture of Gall Bladder"	*Thayer Hospital* Dr. J. O. Piper "Appendicitis from Medical Point of View"	*Thayer Hospital* Dr. E. H. Risley "Acute Appendicitis, Surgical Viewpoint"	*Thayer Hospital* Dr. N. Bisson "Complications of Appendicitis"
Sanatorium Dr. George Young Operative Clinic Thoracoplasty		*Sanatorium* Dr. W. Modarelli Dry Clinic "Bronchial Conditions—Differential Diagnosis—Bronchography"	*Sanatorium* Ward Rounds
Sisters' Hospital Dr. E. W. Harlow "Cancer of Breast"	*Sisters' Hospital* Dr. J. C. Michaud "Meningitis"	*Thayer Hospital* Dr. J. P. Goodrich, et als. Demonstration of Films "Problems of Interest to the General Practitioner"	
Thayer Hospital Dr. T. E. Hardy "Bronchial Asthma"	*Thayer Hospital* Dr. J. R. Mabee "Congenital Malformations of the Mouth"	*Sisters' Hospital* Dr. B. O. Goodrich, et als. "Hospital Obstetrics"	*Sisters' Hospital* Dr. P. S. Merrill "Analgesia in Obstetrics"
Thayer Hospital Dr. W. E. Kershner Dry Clinic Ophthalmology	*Thayer Hospital* Dr. H. F. Hill "Head Injuries"	*Elm City Hospital* Dr. C. E. Towne Dry Clinic Gynecology	*Sisters' Hospital* Dr. V. C. Totman "Panophthalmitis"
Sisters' Hospital Dr. J. E. Poulin "Fracture of Nose"	*Sisters' Hospital* Dr. T. C. McCoy "Acute Otitis Media and Mastoiditis"	*Thayer Hospital* Dr. E. R. Irgens Histopathological Demonstration—"Tumors of Ear, Nose and Throat"	*Thayer Hospital* Dr. F. T. Hill "Osteomyelitis of Skull"

Thursday Evening

6.30 P. M.—Dinner, Elmwood Hotel.

7.30 P. M.—Regular meeting of Kennebec County Medical Society. Speaker—Elliot C. Joslin, M. D., Boston, "Diabetes."

Ladies Entertainment Committee—Mrs. F. T. Hill, Mrs. L. A. Guite, Mrs. Charles E. Towne.

Wednesday Afternoon—Tea and bridge for visiting ladies at the Elmwood Hotel.

Thursday Afternoon—Trip to Mayflower Hill, new Colby College development.

County News and Notes

Kennebec

A meeting of the Kennebec County Medical Association was held at the Augusta General Hospital on Thursday, September 21, 1939.

Clinical Session at 5 P. M., which was presided over by Leon D. Herring, M. D., President:

(1) Ruptured Appendix in Patient 90 Years of Age, N. M. Murphy, M. D.

(2) Ochsner's Treatment in Case of Ruptured Appendix, L. D. Herring, M. D.

(3) Excision of External Saphenous Vein for Varicose Ulcers, M. T. Shelton, M. D.

(4) Traumatic Injury of Face, W. J. O'Connor, M. D.

Dinner at 6.30 P. M., which was followed by a business meeting.

Minutes of the last meeting were read and approved.

The applications of Edward E. Sayer, M. D., Augusta, Maine, and Pierre E. Provost, M. D., Augusta, Maine, were received and referred to the Board of Councilors.

George H. Pratt, M. D., President of the Maine Medical Association, was present and spoke relative to the affairs of the Association, especially the Wagner Bill which is before Congress.

Frederick T. Hill, M. D., Waterville, outlined the program for the Fall Clinical Session which will be held at Waterville on October 25 and 26, 1939.

The address of the evening was given by Henry C. Marble, M. D., Chief of the Fracture Clinic of the Massachusetts General Hospital, whose subject was "Compound Injuries of the Hand, Wrist and Forearm." He stressed the importance of a thorough physical and neurological examination of every compound injury of the hand and forearm, outlining in detail the treatment. This paper was very interesting and instructive, and was followed by a general discussion.

There were 37 members and guests present.

Respectfully submitted,

Frederick R. Carter, M. D.,
Secretary.

Removal Notices

Isaac M. Webber, M. D.
From 188 State St., Portland, Maine
To 29 Deering St., Portland, Maine

Harold Goldman, M. D.
From Freeport, Maine
To Denver, Colo.

Edwin W. Kay, M. D.
From Philadelphia, Pa.
To 671 Main St., Lewiston, Maine

George I. Gould, M. D.
From Andover, Maine
To 325 Alfred St., Biddeford, Maine

Onil B. Labbe, M. D.
From Presque Isle, Maine
To Van Buren, Maine

Coming Meetings

County

Kennebec County Medical Association, Frederick R. Carter, M. D., Augusta, Me., Secretary.

October 26th, Waterville, Me. Speaker: Elliott P. Joslin, M. D., Boston, Mass.

November 16th, Gardiner General Hospital, Gardiner, Me. Speaker: Louis E. Phaneuf, M. D., Boston, Mass.

December 21st, Augusta State Hospital, Augusta, Me. Speaker to be announced later.

State

Maine Medical Association. Fall Clinical Session, Wednesday and Thursday, October 25-26, 1939, Waterville, Me. Clinics at Central Maine Sanatorium, Elm City Hospital, Sisters' Hospital, and Thayer Hospital. Program in this issue.

Necrology

Alfred Loomis Sawyer, M. D., 1881-1939

Doctor Sawyer was born in Lisbon Falls, Maine, on December 23, 1881, coming to Fort Fairfield when he was a child. He was the eldest son of the late Doctor Alfred D. Sawyer and Mrs. Mabel Spear Sawyer, now of Fort Fairfield, Maine.

He received his preliminary education at the Fort Fairfield High School, graduating from there in 1900. He continued with his higher education at Bowdoin College, graduating with his Arts degree in 1904. His medical education was received at Bowdoin Medical School and he graduated from there with his M. D. in 1907. He then returned to Fort Fairfield and was associated with his father in general practice. He continued with his general work until 1926 at which time he took a postgraduate course and then returned to Fort Fairfield, limiting his practice to the Specialty of Eye, Ear, Nose and Throat.

Doctor Sawyer enlisted during the World War in the Spring of 1918 and was stationed at Chattanooga at the close of the war with the rank of First Lieutenant in the U. S. Medical Corps. He was a member of the Maine Medical Association and of the Aroostook County Medical Society. He was also a member of the Masonic Lodge, the Shrine, and of the Walter Lovely Post of the American Legion.

To those who have had the opportunity to know and to work with him he possessed one of those rare qualities that few of us have. He was always on the alert, seeing all things, hearing all things, sympathetic to the extreme. He had little to say but when he did speak his words meant something and were not wasted. He was a great lover of nature and the out-of-doors and his end came when he was on a camping trip with his family whom he worshipped.

He is survived by his wife, Mrs. Eva Mills Sawyer; four sons, Thomas M., A. Loomis, Herbert S., and Robert B.; his mother, Mrs. Mabel Sawyer; two brothers, Warren S. Sawyer of Fort Fairfield, and Herbert G. Sawyer of Bangor.

Notices

Panel Discussions Available

"The following panel discussions are available for County Medical Society programs. Application for these should be made to the Chairman well in advance if possible so that arrangements can be made for presentation."

"Pneumonia," Dr. F. T. Hill, Waterville, Chairman.

"Cardio-Renal Diseases," Dr. E. E. Holt, Jr., Portland, Chairman.

"Fractures," Dr. Allan Woodcock, Bangor, Chairman.

"Acute Appendicitis," Dr. F. H. Jackson, Houlton, Chairman.

"Laboratory Procedures," Dr. Julius Gottlieb, Lewiston, Chairman.

"Thoracic Surgery," Dr. George Young, Skowhegan, Chairman.

"Blood Dyscrasias," Dr. L. H. Smith, Winterport, Chairman.

"Convulsions," Dr. T. A. Foster, Portland, Chairman.

Bureau of Health Services for Crippled Children Clinic Schedule

Bangor: *Eastern Maine General Hospital* — 1.00 to 3.00 P. M., Thursday, October 19th, November 16th, December 14th.

Fort Kent: *Normal School* — 9.00 to 11.00 A. M., 1.00 to 3.00 P. M., Tuesday, December 5th.

Lewiston: *Central Maine General Hospital* — 9.00 to 11.00 A. M., Saturday, October 28th, November 25th, December 30th.

Machias: *Normal School* — 1.00 to 3.00 P. M., Wednesday, October 18th.

Portland: *Children's Hospital* — 9.00 to 11.00 A. M., 1.00 to 3.00 P. M., Monday, November 13th, December 11th.

Presque Isle: *Northern Maine Sanitarium* — 9.00 to 11.00 A. M., 1.00 to 3.00 P. M., October 24th, December 6th.

Rockland: *Knox County Hospital* — 1.30 to 3.00 P. M., Thursday, December 21st.

Rumford: *Rumford Community Hospital* — 1.30 to 3.00 P. M., Wednesday, November 22nd.

Waterville: *Thayer Hospital* — 1.30 to 3.00 P. M., 1.30 to 3.00 P. M., Thursday, November 30th.

N. B.: This clinic schedule is subject to change. If changes are necessary, adequate notice will be given.

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*Tumor Clinics**

Portland: *Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Mortimer Warren, M. D.*

Lewiston: *Central Maine General Hospital*—Tuesday, 10.00 A. M.-12.00 M. Director, *E. V. Call, M. D.*

St. Mary's General Hospital—Wednesday, 4.00 P. M. Director, *R. A. Beliveau, M. D.*

Waterville: *Thayer Hospital* — Thursday, 9.00-11.00 A. M. Director, *Edward H. Risley, M. D.*

Sisters' Hospital — Thursday, 9.00-11.00 A. M. Director, *Blynn O. Goodrich, M. D.*

Bangor: *Eastern Maine General Hospital*—Thursday, 11.00 A. M.-12.00 M. Director, *Magnus F. Ridlon, M. D.*

* Approved by Maine Medical Association.

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Millinocket, Old Town, Portland, Presque Isle, Rockland, Rumford, Sanford, Waterville, Wilton, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

New England Postgraduate Assembly

October 31 and November 1—Sanders Theatre, Harvard University, Cambridge, Massachusetts

Sponsored by the Massachusetts, New Hampshire, and Rhode Island Medical Societies, the Maine Medical Association and the Vermont State Medical Society.

PROGRAM

Tuesday, October 31

MORNING SESSION

10.00 Dr. Jesse G. M. Bullowa, New York City. "Basis of Specific Therapy in the Management of the Pneumonias."

10.30 Dr. Roscoe R. Graham, Toronto, Ontario. "Chronic Cholecystitis."

INTERMISSION

11.15 Dr. Albert C. Furstenberg, Ann Arbor, Michigan. "Acute Suppurations of the Mouth and Pharynx."

11.45 Dr. Joseph Earle Moore, Baltimore, Maryland. "Unsolved Problems of Syphilis."

12.15 Luncheon—Presiding Chairman: Dr. Edwin A. Hyatt. Address by Dr. James S. McLester. "What New Englanders Should Know About the Practice of Medicine in the South."

AFTERNOON SESSION

1.45 Dr. Charles C. Higgins, Cleveland, Ohio. "A Clinical Review of Malignant Tumors of the Kidney."

2.15 Sir Thomas Lewis, Rickmansworth, England. "Venous Congestion and Its Measurement."

INTERMISSION

3.30 Dr. James S. McLester, Birmingham, Alabama. "The Role of the Vitamins and Other Essential Substances in Human Nutrition."

4.00 Dr. Jesse G. M. Bullowa, New York City. "Serum and Sulfapyridine in the Management of the Pneumonias."

4.30 Dr. Roscoe R. Graham, Toronto, Ontario. "Duodenal Ulcer."

7.00 Dinner—Memorial Hall. Speaker: H. H. Clegg, Assistant Director of the Federal Bureau of Investigation, United States Department of Justice, Washington, D. C. "War on Crime by F. B. I."

Wednesday, November 1

MORNING SESSION

9.00 Dr. Benjamin W. Carey, Detroit, Michigan. "Pyelitis in Children."

9.30 Dr. Albert C. Furstenberg, Ann Arbor, Michigan. "Sinus Disease in the General Practice of Medicine."

10.00 Dr. Eldridge L. Eliason, Philadelphia, Pa. "Team Work in the Treatment of Gall-Bladder Disease."

10.30 Dr. James B. McLester, Birmingham, Alabama. "The Disorders Which Commonly Result From Nutritive Deficiency and Their Treatment."

INTERMISSION

11.15 Dr. Joseph Earle Moore, Baltimore, Maryland. "Latent Syphilis."

11.45 Dr. Harvey B. Matthews, Brooklyn, New York. "Pelvic Infection: Diagnosis and Management."

12.15 Dr. Maurice C. Pincoffs, Baltimore, Maryland. "Clinical Varieties of Hypertension."

12.45 Luncheon—Followed by question period. (Presiding Chairman: Dr. James B. Woodman.) Questions by Dr.

AFTERNOON SESSION

1.45 Dr. Charles C. Higgins, Cleveland, Ohio. "Prevention of Recurrent Renal Lithiasis."

2.15 Dr. Benjamin W. Carey, Detroit, Michigan. "Pneumonia in Children."

2.45 Dr. Eldridge L. Eliason, Philadelphia, Pa. "The Patient and His Fracture."

INTERMISSION

3.30 Dr. Maurice C. Pincoffs, Baltimore, Maryland. "The Eastern Form of Rocky Mountain Spotted Fever."

4.00 Dr. Roscoe R. Graham, Toronto, Ontario. "Heparin."

4.30 Dr. Harvey B. Matthews, Brooklyn, New York. "Gynecological Backache: Causes and Management."

Book Reviews

"Baptism of the Infant and the Fetus: An Outline for the Use of Doctors and Nurses"

By the Rev. J. R. Bowen, Chaplain, St. Joseph Mercy Hospital, Dubuque, Iowa. Paper, 25 cents. Fourth Edition. M. J. Kippel Company, 1939.

This outline of the Sacrament of Baptism, that it may be properly administered in any emergency, is submitted for the use of Catholic and non-Catholic physicians and nurses officiating at deliveries. Published under official Catholic auspices it is easily read and understood and should be available for reference in the maternity department of all hospitals.

As stated in the foreword by Father Bowen it is necessary in many cases that the baptismal rites be entrusted to doctors and nurses, time and circumstances often render the calling of a priest impossible, and he graciously acknowledges the appreciation of the Church of the coöperation of non-Catholic physicians and nurses in its beliefs and teachings. Conscientious physicians of any creed will surely regard this service as a professional duty and the suggestions of the author welcomed in the spirit they are offered.

"Practice of Allergy"

By Warren T. Vaughan, M. D., Richmond, Va. Published by The C. V. Mosby Co., St. Louis. 1939. Price, $11.50.

The student of allergy must be reasonably conversant not only with botany, mycology, bacteriology, dietetics, but with the various medical specialties as well, such as dermatology, gastroenterology, otorhinolaryngology, pediatrics, psychiatry, etc. In order to be able to present his "Practice of Allergy" most advantageously, the author wisely demands a clarification, appropriate evaluation and standardization of the meanings of such often misapplied terms like anaphylaxis, allergy, protein poisoning, atopy, sensitization, hypersensitiveness, antigen-antibody, allergen, atopen, reagin, shock organ and shock tissue, idiosyncrasy and hyperergy. It appears that about ten percent of the population at large suffer from frank allergy, i. e., major allergy, while an additional 40 to 50 percent have or will have experienced some minor evanescent allergic manifestations, most often not sufficiently pronounced to require medical consultation, during some part of their life span. The correctness of this apparently large percentage of people with minor allergy was cleverly elicited by the author among people he knew to be ordinarily considered nonallergic.

The author believes that all persons possess the potentiality to become allergic. The response to allergenic substances, however, depends partly upon inheritance, partly on the nature of the allergen and partly on the degree and duration of exposure. The difference in response between the so-called allergic and the so-called nonallergic person is one of degree or distribution and not of kind. "It is a purposeful reaction, purposelessly executed, a perversion of the function of protecting the body against deleterious environmental maladjustment. It represents a response to an environmental maladjustment."

Since there are many more allergic diseases than the so-called original ones, like hay fever, asthma, urticaria, dermatitis, acute circumscribed edema, migraine, gastrointestinal allergic disturbances, etc., the author recommends that everyone should learn by self-observation what substances produce symptoms of discomfort, so that one may learn to avoid, as far as is possible, these discomfort-producing agents. This sort of self-analytical medical service should be kept up day by day, and a correct record should be kept for the whole family. Thus will it be possible to gradually establish a record of characteristic familial idiosyncracies and learn of the appropriate remedial agencies.

This remarkably well edited book is made up of sixteen parts and fifty-three chapters. Part One comprises an introductory and historical chapter, one on the theories of anaphylaxis and one on the clarification of terminology. Part Two concerns itself with general characteristics of clinical allergy. In Part Three the physiology of allergy is described. Parts Four, Five and Six, comprising twenty-three chapters, deal with diagnosis of allergic conditions, diagnosis and treatment of food allergy, and food allergen. In Part Seven, consisting of seventeen chapters, the various phases of pollens, pollinosis and diverse inhalant allergy are described and illustrated. Bacteria and fungi make up the material for the Eighth and Ninth parts, entomogenous and percutaneous allergy the Tenth. The subject of anaphylactic shocks covers Part Eleven. Parts Twelve, Thirteen and Fourteen deal with drug, contact, and physical allergy, respectively; Part Fifteen with phamacology and Part Sixteen with allergic diseases. There is an extensive bibliography and a good index. On the whole, it appears that this text fills a long-felt gap in medical literature; it is of excellent quality and almost universally applicable.

"Varicose Veins"

By Alton Ochsner, B. A., M. D., D. Sc. (Hon.), F. A. C. S. William Henderson Professor of Surgery and Director of the Department of Surgery, School of Medicine, Tulane University of Louisiana, New Orleans, La.; and Howard Mahorner, B. A., M. D., M. S. (Surgery), F. A. C. S. Assistant Professor of Surgery, School of Medicine, Tulane University of Louisiana, New Orleans, La.

Published by The C. V. Mosby Company, St. Louis, 1939. Price, $3.00.

After the authors have presented a short historic sketch of the care and treatment of varicose veins by the physicians and surgeons of bygone days, they tell the reader how to correctly diagnose and treat varicosities by present-day methods. They recommend that the functional efficiency of the varicosed veins be tested by the Brodie-Trendelenburg test and by the comparative tourniquet test, devised by Mahorner and Ochsner. They mention several other tests but they are of the opinion that these two are superior to all others combined.

For arterial functional tests, they recommend the Histamine test, but contrary to De Takats and Quint, who test all patients over 50 years of age, the authors test all patients whenever the efficiency of the arterial blood supply is doubtful.

Concerning the treatment, the authors presume that the existence of varicose veins is indication enough for some sort of treatment. However, they carefully reserve so-called active therapy, i. e., treatment by injection and surgery, to those patients who are not of advanced age, who are not in the pregnant state, who do not suffer from debilitating diseases or from any severe impairment of the arterial blood supply, and those who do not have a history of phlebitis of the deep veins or of any form of mechanical obstruction to the return venous flow, which has its seat in the pelvis. The technique of preventative, conservative, and active treatment is described in detail.

"An Introductory to Sociology and Social Problems—A Textbook for Nurses"

By Deborah MacLurg Jensen, R. N., B. Sc. Social Service Consultant to the Visiting Nurse Association, St. Louis; Lecturer in Nursing Education, Washington University; Formerly Assistant Director, School of Nursing, Washington University, St. Louis.

Published by The C. V. Mosby Co., St. Louis, 1939. Price, $2.75.

The newer teachings of student nurses now includes a course in sociological subject matter. During many years of theoretical and practical experience in dealing with the social problems of the well and the sick, the author has accumulated a wealth of useful knowledge. From this large store she has selected the best, compiled it into book form and hopes that it will serve to teach the student nurses the theory of social service work, as the nurse will find it and as she must meet it in her everyday duties. Since only a comparatively short time is allowed for courses of this nature, the author has included only such subject matter as is clearly understandable and of fundamental importance. Those who wish to penetrate more deeply into the science of sociology, whether as student or as teacher, may find considerable stimulation to proceed by consulting the bibliographical references at the end of each part.

Section I, sociology, deals with man's social nature and the development of personality, collective behavior, the community, the family, and social change. In Section II, social problems, the student learns about the individual's reaction to illness and social problems in the modern community.

The book is printed on "eye-toned" paper.

"Life and Letters of Dr. William Beaumont"

By Jesse S. Myer, A. B., M. D. Late Associate in Medicine in Washington University, St. Louis, with an introduction by Sir William Osler, B. T., M. D., F. R. S., Late Regius Professor of Medicine in Oxford University, England.

Published by The C. V. Mosby Co., St. Louis, 1939.

It is an exceptional contemporary happening that a new print of this great American classic should appear at this time. This work is especially well chosen because it so beautifully illustrates the life of the scientifically inclined American physician of a hundred years ago. It would be difficult to find a better pictorization of the American form of spirit of scientific medical investigation, in this particular instance, the investigation of gastric digestion in the living laboratory of Alexis St. Martin, carried on for many years through a fistulous opening leading from his stomach to the outside world. What was true in 1912 when Dr. William Osler wrote the introduction to the original publication is still true today: "The man was greater than his work; and it is well that the story of Beaumont's life should be told by a member of the profession of the city of which for so many years he was a distinguished ornament." However, it must not ever be forgotten that almost the entire Eastern section of our country played an important part in the life and work of this pioneer physiologist of these United States. Even though few were, and perhaps still are, the pilgrims who know and visit his grave, in his life he was an unique and remarkable man. "All mankind has profited by virtue of his having lived and worked."

"The Organism—A Holistic Approach to Biology Derived from Pathological Data in Man"

By Kurt Goldstein, M. D., Columbia University, with a Foreword by K. S. Lashley, Harvard University. Published by The American Book Company, New York, 1939. Price, $4.00.

So far as is known to this reviewer, this is the first time that the study of the human organism from the holistic point of view is presented to the American medical public; the psycho-biologic approach of Dr. Adolf Meyer is its predecessor in kind. It is the English version of the author's work, previously issued in the German language.

In the first four chapters the various methods of the study of human behavior are critically compared; the next eight chapters are devoted to the development of the evolution of the body as a whole theory with special reference to the author's views on holistic relationships of performance. Especially the seventh chapter, entitled "The Organism and the Holistic Approach," should be of considerable interest to the physician who looks for a reasonable explanation of the behavior of the normally functioning man, of the man whose behavior is altered on account of injury to the brain and nervous system, and of the behavior of that great multitude of people who are always in a state of anxiety and neurotic unrest of various kinds, etc. He tells us that "anxiety appears when it has become impossible for an organism to cope in any way with tasks which are commensurate to its real nature." Amplifying the relationship between anxiety and fear, he answers the question, "What leads to fear?" by saying, "the experience of the possibility of the onset of anxiety. What we fear is the impending anxiety." The elaboration of these statements as presented in the text will help considerably in understanding the development of the neuroses which often evolve during a person's repeated attempts at readjustment to the environmental demands. The author here also describes and explains the characteristics of "preferred behavior" in various ways to different situations and states that "the tendency towards preferred behavior is an expression of the fact that the organism seeks ever and again a situation in which it can perform adequately." In chapter ten the author ventures to establish the presence of reasonable prerequisites which may be employed to determine the existence of such states which are ordinarily designated by the terms normal, health, disease, and he demands that especially the desig-

nations disease, sickness, disorder, etc., must be based upon knowledge of the individual organism's previous state of being while functioning appropriately to the then prevailing environmental requirements. He considers it necessary that the physician, in treating patients suffering from situation conflicts, remembers that "such treatment will always have to be guided by the consideration as to whether the shrinkage of the milie, which every treatment entails, does not limit, for the individual, the possibilities of self-actualization beyond the point of what is bearable." True to the holistic notion of preferred behavior, he permits, in fact recommends, that the physician allow the patient considerable freedom of choice between his limitations in his milieu by virtue of medically necessary commands and his voluntary endurance of suffering for the gain of greater preferred behavior freedom. In the eleventh chapter the author presents what should appear to be a clarification of the rather widely accepted notion that man and man alone seems to live through his most severely painful experiences on account of the action of forces which work antagonistically to the natural enjoyment of life according to the rules of "preferred behavior." Unhappily he calls it the life-mind antagonism, thus covering the trap which he promised to uncover. That definite and often fatal antagonisms exist and act not only against the life of every human being but also against the holistic approach to the explanation of all of human life, the author knows of course, as is revealed by his statement in regard to one of them: "Every technology means violence to nature; and even where it utilizes or exploits natural energies by direct manipulation, it is able to serve its purpose only in opposition to nature." He demands clear, unambiguous terms in which antagonistic forces can be defined and described. So far as this reviewer is acquainted with the literature available with regard to body-soul agonism and soul-spirit antagonism, it seems that there do exist reasonably clear, unambiguous terms by which the characteristic differences have been described and most of the requirements needed for the formation of a workable concept have been satisfied so far as this is possible at the present stage of our knowledge. It seems that much of this literature should be made accessible at least to the medical profession since they are almost always that body of men who must deal with all aberations of the human body (physical structure and processes), soul (physiologic function and psychic feeling), and spirit (intellectual manipulation of symbols including calculation, etc.).

Perhaps it is not important that we try to invent a group of terms which satisfies everybody but to us as physicians it is all important that we inform ourselves regarding all of the characteristic features of the directly or indirectly demonstrable expressions of these forces when in action. To deny their existence or not to recognize the possible extent of their destructiveness to man is a fatal error. We are confronted with the task of solving our patients' problems every day of our practice in all three of these spheres and we cannot adequately perform our duty to them if by merely responding to "preferred behavior" tendencies active within ourselves, we choose to remain uninformed on matters not as prominently manifest as form and function of the individual human organism but often considered more important than either to the welfare of a community of human beings, especially in our modern society.

The medical and allied professions should welcome the publication of this book and should, by combined effort, see to it that there shall soon be published works of American investigators as well, along similar lines. We must persistently strive to relearn the workings of old truths in new relationships with special reference to the functioning of the human organism as a whole.

A CONVENIENT OFFICE TREATMENT FOR TRICHOMONAS VAGINITIS

SILVER PICRATE
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THIS simple treatment requires but two office visits, a week apart, for insufflations and the nightly insertion of a Silver Picrate suppository for twelve nights.

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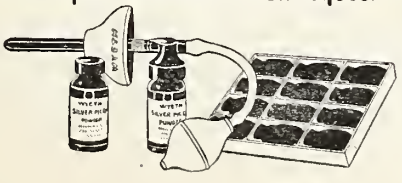

JOHN WYETH & BROTHER, INCORPORATED, Philadelphia, Pa.

"Epidemic Encephalitis—Etiology, Epidemiology, Treatment"

Third Report by The Matheson Commission, Willard C. Rappleye, Chairman. Columbia University Press, New York, 1939. Price, $3.00. Price of first report, 1929, $3.00. Price of second report, 1932, $1.50. Price for first, second and third report, purchased together, $6.00.

The reports of the Matheson Commission are very timely and should prove to be of great interest to the medical profession, especially since it has been proven beyond doubt that the virus of Western Equine Encephalomyelitis is transmissible to man. This finding makes it necessary to consider this virus as well as the Japanese virus and, of course, the St. Louis virus, as possible causes of Epidemic Encephalitis. Each type seems to command a rather high fatality among the victims attacked.

Concerning treatment of encephalitis, this report states that it is very difficult to correctly evaluate any one method or agent. It seems that since there have been no recent major outbreaks of epidemic encephalitis, the recently introduced sulfanilamide and allied preparation have not been tested, judging from their absence from this report. "In studying a disease like encephalitis in which for the most part a little is done here and a little there, it is of great importance that a center be established and maintained to deal solely with this problem. No small part of our work at the present time consists in giving consultation service to physicians from all parts of the country, either personally or by letter. So far as we know, the Matheson Commission is the only unit continuously and intensively studying this disease."

The textual material contained in this, the third report, comprises 178 pages, while the bibliographical section of 297 pages presents references from the literature dealing with epidemic encephalitis and allied diseases published in the medical and allied science literature of the entire world, so far as known.

"Operative Orthopedics"

By Willis C. Campbell, M. D., Memphis, Tenn. 1,154 pages, 845 illustrations. Published by The C. V. Mosby Company, St. Louis, Mo., 1939. Price, $12.50.

Orthopedic reconstruction or operative orthopedic is a highly specialized field in the realm of surgery of the bones and other supportive tissues. This volume has been written for the purpose to supply specialists in orthopedic, industrial and general surgery with the best information available concerning the work done in this field. Surgery of the bones is a comparatively young branch of the medical arts and has been practiced successfully on a large scale only since aseptic technique has been perfected and the healing of bone and tendon tissue has become better known. The numerous methods and techniques described and illustrated in this remarkable work supply the theoretic bases for the surgical performances. Most of the operations, with the exception of arthroplasty and arthrodesis are grouped according to the applicability of corrective surgery to certain affections. The after-treatment is described in detail after the outline of the operative techniques. The end-results are estimated according to most reliable information obtainable; in many cases a period of twenty or more years of successful postoperative performance forms the basis for evaluation of results obtained. If more than one technique is employable, the author gives preference to that one which he found by actual experience to be the best for the case in hand. The goal aimed at was always the attainment of best anatomic and physiologic results. "Operative Orthopedics" should prove to be a very welcome addition to the medical literature. It is a guide and record of the art of surgical reconstruction.

"Manual of the Diseases of the Eye—For Students and General Practitioners"

By Charles H. May, M. D., Consulting Ophthalmologist to Bellevue, Mt. Sinai and French Hospitals, New York; Formerly Chief of Clinic and Instructor in Ophthalmology, Medical Department of Columbia University, and Director of the Eye Service at Bellevue Hospital, New York. Sixteenth Edition, Revised, with the Assistance of Charles A. Perera, M. D., Instructor in Ophthalmology, College of Physicians and Surgeons, Medical Department of Columbia University, New York. Published by William Wood and Company, Baltimore, 1939. $4.00.

Once again the new May makes its appearance, slightly enlarged but greatly revised. An added feature is the visual standards for operating motor vehicles as approved by the American Medical Association. There have been alterations in the chapters on glaucoma, lens, retina, optic nerve, and errors of refraction. There is a separate chapter for perforating wounds and foreign bodies in the globe with a section dealing with compensation for eye injuries, estimated in accordance with the A. M. A. appraisal of loss of visual efficiency scales. In its sixteenth edition, May is still the friend of the medical student as well as the general practitioner of many countries and languages. This work has been published in nine languages and has gone through over forty revisions.

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The Chemotherapy of Pneumonia†*

By Francis G. Blake, M. D., New Haven, Connecticut

The chemotherapy of pneumonia, which has been a subject of intermittent investigation for many years, particularly with quinine and its derivatives[1], received a new impetus following the introduction of prontosil by Domagk[2] in 1935 and the subsequent demonstration[3] that the simpler compound, sulfanilamide, was the therapeutically effective component of the azo dye. Applied successfully at first in B-hemolytic streptococcic infections[4], including streptococcic pneumonia[5], sulfanilamide was soon reported by several authors[6] to possess considerable value in pneumococcic infections in laboratory animals. Because of this it undoubtedly has been tried extensively in pneumococcic pneumonia in man. The paucity of reports[7] concerning its use in this disease, however, can leave little doubt that it has not been as conspicuously successful as appears to be the case with the newer drug sulfapyridine, introduced by Whitby[8] in 1938.

Already within the brief space of a year numerous highly favorable reports[9] on sulfapyridine, which will not be reviewed in detail here, have been published. Since it seems important not only that the chemotherapeutic efficacy of sulfapyridine be evaluated but also that the difficulties involved in its clinical application receive proper emphasis, it is proposed in this discussion first to summarize briefly the results which we have obtained in the treatment of pneumonia with sulfapyridine* and then to consider somewhat more in detail some of the problems encountered in its use.

Therapeutic Results

The clinical material which forms the basis of this report consists of 156 cases of pneumonia treated with sulfapyridine at the New Haven Hospital between November 30, 1938, and June 10, 1939. The cases are divided into four groups on etiological grounds as follows: (1) pneumococcic lobar pneumonia, 114 cases; (2) B-hemolytic streptococcic pneumonia, 1 case; (3) staphylococcic pneu-

* The sulfapyridine used was obtained through the courtesy of Merck & Co.

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monia, 6 cases; and (4) bronchopneumonia of variable, sometimes indeterminate etiology, 35 cases. Obviously the material is too limited and heterogeneous to warrant either statistical analysis or final conclusions at this time and this will not be attempted.

Pneumococcic Lobar Pneumonia.—Brief data on the 114 cases of pneumococcic lobar pneumonia are shown in Table I, from which it will be seen that 79 were treated with sulfapyridine alone, 35 with anti-pneumococcus serum and sulfapyridine. The occurrence of only 4 deaths among the 79 patients treated with sulfapyridine alone at least speaks encouragingly for its therapeutic value in lobar pneumonia, and particularly so when it is pointed out that there were no fatalities among the 68 patients under sixty years of age nor among the 7 bacteremic cases.

Table I—Pneumococcic Lobar Pneumonia

Pneumococcus Type	Treated with Sulfapyridine Alone					Treated with Sulfapyridine and Anti-pneumonia Serum					TOTAL		
	Cases	B. C.+	Recovered	Complications	Died	Cases	B. C.+	Recovered	Complications	Died	Cases	B. C.+	Died
I	13	3	13	1[1]	0	14	4	14	2[2,3]	0	27	7	0
II	0					3	1	3	1[4]	0	3	1	0
III	14	0	11	0	3	0					14	0	3
IV	7	1	6	0	1[6]	4	0	3	0	1	11	1	2
V	11	1	11	1[3]	0	4	1	4	2[3,6]	0	15	2	0
VI	2	0	2	0	0	0					2	0	0
VII	3	0	3	0	0	4	2	4	1[2]	0	7	2	0
VIII	2	0	2	0	0	4	2	3	1[7]	1	6	2	1
XII	1	1	1	0	0	0					1	1	0
XIII	1	0	1	1[3]	0	0					1	0	0
XIV	12	1	12	0	0	1	1	0	0	1	13	2	1
XV+	13	0	13	0	0	1	0	1	0	0	14	0	0
Total	79	7	75	3	4	35	11	32	7	3	114	18	7

B. C.+ = Positive blood culture.

[1] Sterile pleural effusion. [2] Organizing pneumonitis and lung abscess (superimposed staphylococcic infection). [3] Empyema. [4] Empyema on admission resolved under medical treatment. Temporary hemiplegia. [5] Agranulocytosis. [6] Empyema present on admission. [7] Thrombophlebitis.

The results in the small group of 35 cases in which combined serum and sulfapyridine therapy was used were equally satisfactory. Here too, there were no deaths in the cases under sixty years of age and only one among the 11 bacteremic cases, although 7 were over forty years of age. To what extent, if any, sulfapyridine may have contributed to the favorable results in this group is obviously impossible to say. At least our experience with serum alone in early cases of lobar pneumonia would lead us to suspect that the sulfapyridine was quite gratuitous in those of less than 60 hours' duration when serum was administered (Fig. 1).

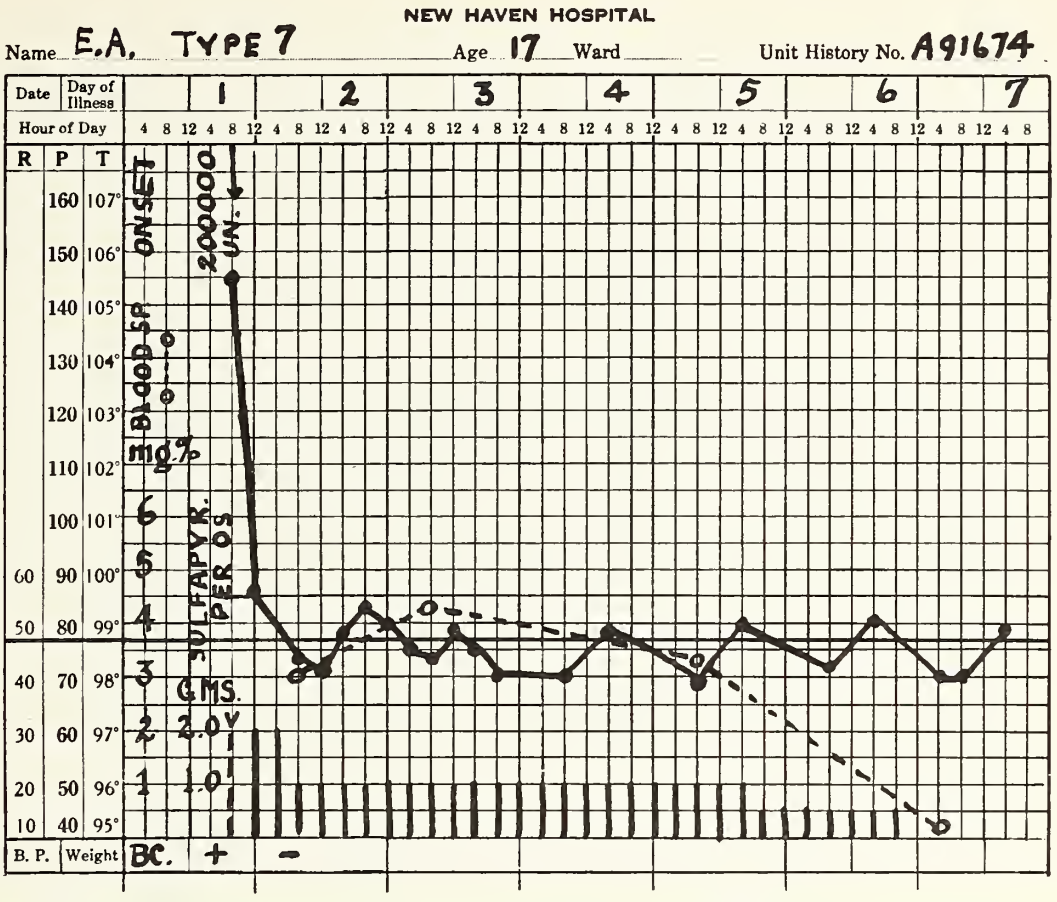

Figure I. Treatment of lobar pneumonia with antipneumococcus serum and sulfapyridine. V. = vomited. BC. = blood culture.

An analysis of the 7 fatal cases (Table II) shows that 6 of them were individuals with severe chronic disease, 3 were advanced cases with extensive bilateral pneumonia when treatment was started, all were of advanced age. The fatal outcome in Case 147 was directly due to sulfapyridine, however, since the patient developed agranulocytosis, from which she died.

Table II—Data on Fatal Cases of Pneumococcic Lobar Pneumonia

Case No.	Age	Chronic Disease	Day of Pneum.	Type Pn.	Site	B. C.	Treatment	REMARKS
4	83	—	4	III	R. U., R. M. R. L., L. L.	—	Sulfapyr.	Advanced bilateral pneumonia. Died 7th day.
41	75	Severe bleeding peptic ulcer. R. B. C. 2,190,000.	2	III	R. U.	—	Sulfapyr.	Course unaffected. Died 7th day.
147	61	Advanced Paget's disease.	4	IV	R. L.	—	Sulfapyr.	Prompt recovery from pneumonia. Developed granulocytopenia on 22nd day. Died 25th day.
10	60	Advanced dermatomyositis.	2	IV	R. L.	—	Serum and sulfapyr.	Pneumonia promptly controlled. Died from dermatomyositis.
70	81	Hypertensive cardiorenal. Azotemia.	1	VIII	R. L.	—	Serum and sulfapyr.	Immediate recovery from pneumonia. Died suddenly on 7th day. ? coronary thrombosis.
63	65	Bilateral pulmonary tuberculosis.	5	XIV	R. U., R. M. R. L., L. L.	+	Serum and sulfapyr.	Advanced bilateral pneumonia. Died 8th day.
175	74	Arteriosclerotic heart disease. Auricular fibrillation.	.5	III	R. L., L. L.	—	Sulfapyr.	Advanced bilateral pneumonia. Died 9th day.

One of the most striking features of sulfapyridine therapy in lobar pneumonia would appear to be its usual prompt effect on the clinical course of the disease as illustrated in Fig. 2. Of the 79 cases treated with sulfapyridine alone, 57 showed a similar critical recovery within 24 hours after institution of treatment and remained well except for certain reactions due to the drug, to be mentioned below. Eleven more recovered by rapid lysis within 48 hours (Fig. 3). Of these, 42 were treated within less than 72 hours after onset, early enough to justify the opinion that the prompt recovery was due in the majority, at least, to the bacteriostatic action of sulfapyridine.

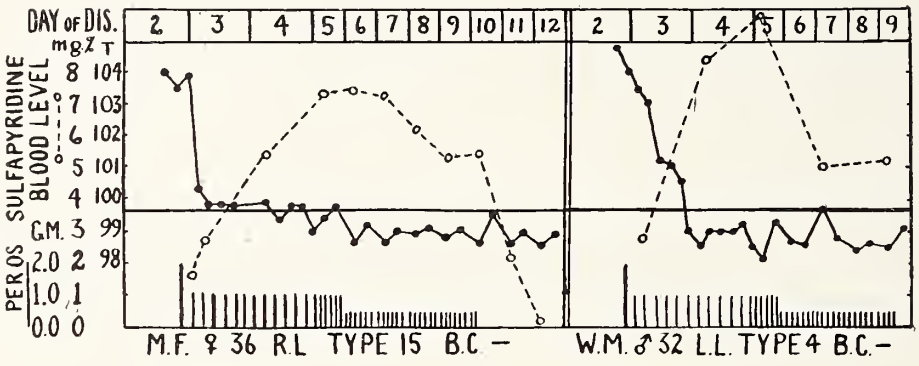

Figure II. Critical cure of early lobar pneumonia with sulfapyridine.

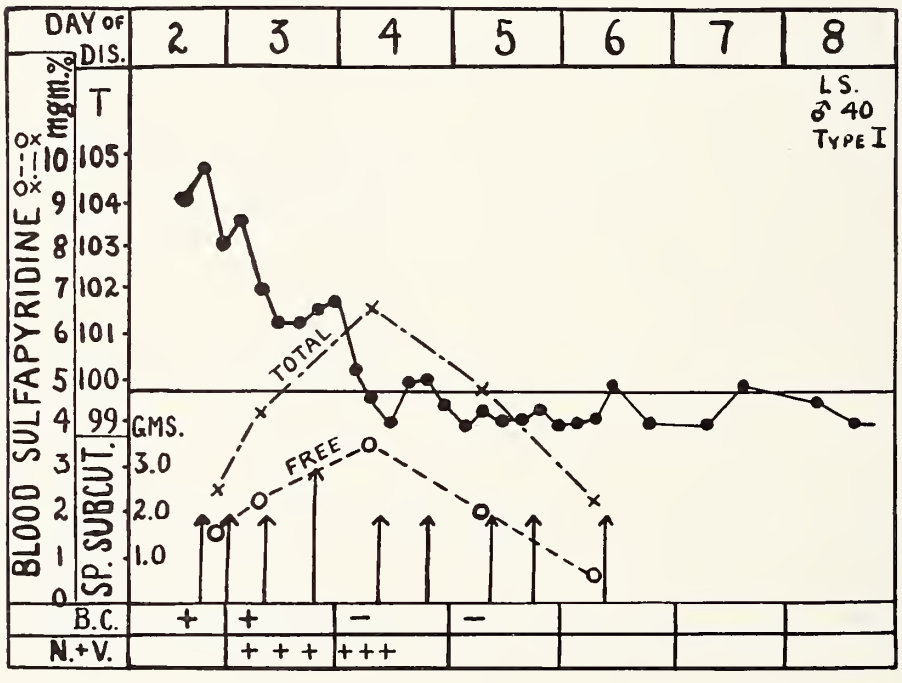

Figure III. Recovery by rapid lysis in bacteremic case of Pn. Type I lobar pneumonia. Sulfapyridine administered parenterally.

Of the remaining 7 recovered cases, 4 sufferred a brief febrile relapse, perhaps due to too early discontinuance of the drug, while three cases developed subsequent complications, in one (Type I) a sterile pleural effusion, in another (Type XIII) empyema, and in the third (Type V) an organizing pneumonitis with lung abscess associated with a superimposed staphylococcus infection. Complications among the 35 patients receiving combined serum and sulfapyridine therapy were a little more frequent (Table I), a difference of no statistical significance, however.

In the evaluation of these results undoubtedly one of the important factors to be taken

into consideration in addition to bacteremia is age distribution, which was as follows:—

Age	Cases	Bacteremic	Deaths
Less than 20 yrs.	56	6	0
20-39 yrs.	20	3	0
40-59 yrs.	18	7	0
60-85 yrs.	20	2	7

Obviously the case fatality rate of 6.1 per cent in this series, as might be expected from previous experience, is significantly influenced by the relatively small number of patients over sixty years of age.

Streptococcic Pneumonia.—Only one case of B-hemolytic streptococcic pneumonia has been treated with sulfapyridine, a severe case with empyema. The clinical course is shown in Fig. 4, from which it will be seen that the patient responded very satisfactorily with resolution of the empyema under chemotherapy and repeated thoracentesis, a result comparable to that which may occur with sulfanilamide[5].

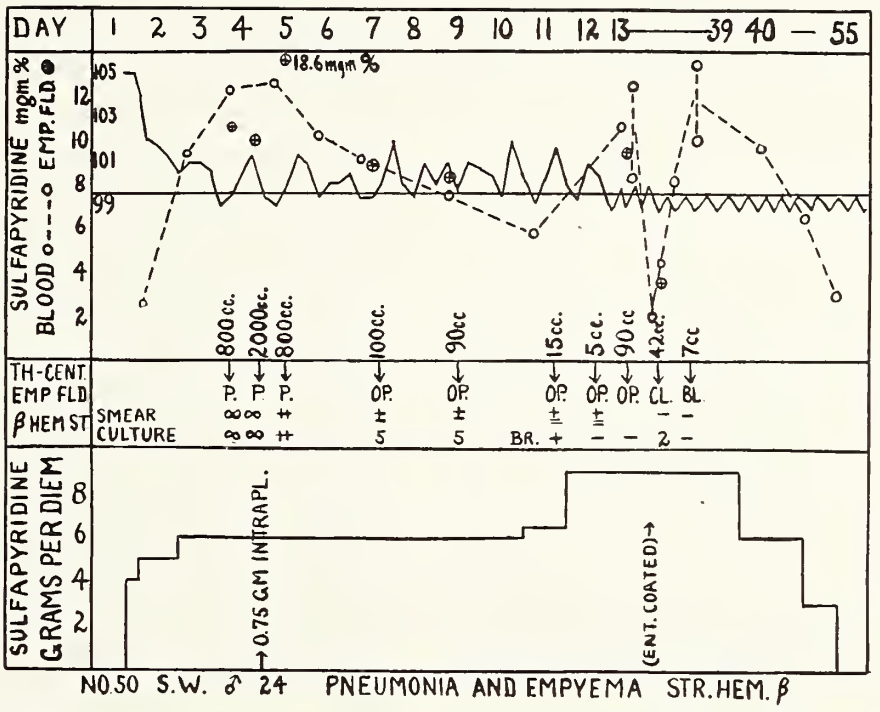

Figure IV. Hemolytic streptococcic pneumonia with empyema. P. = purulent. OP. = opalescent. CL. = clear. BL. = bloody (traumatic).

Staphylococcic Pneumonia.—Six patients with staphylococcic pneumonia treated with sulfapyridine are briefly summarized in Table III. Obviously there is no evidence in this small group of cases that sulfapyridine is of value in severe staphylococcic pneumonia, but undoubtedly it should receive further trial before it can be definitely concluded that it is of no value.

Table III—Staphylococcic Pneumonia

Case No.	Age	Day of Disease	B. C.	RESULT
11	20	1	—	Defervescence in 36 hrs. Lung abscess on 13th day, 6 days after sulfapyridine was stopped. Recovered.
42	47	5	+	No effect. Died 6th day.
65	65	2	—	No benefit. Died 8th day.
72	71	9(?)	—	Apparently moribund on admission. Recovered by lysis in 72 hrs.
77	59	5	+	No effect. Died 6th day.
101	79	2	+	Temporary improvement with subsequent recurrence after discontinuance of sulfapyridine on 8th day. Died on 21st day.

B. C. = Blood culture.

Bronchopneumonia. — Sulfapyridine was tried in 35 cases of bronchopneumonia. In many instances these were mixed infections with virus (?), pneumococci of the higher types, *H. influenza,* etc. Fifteen were in infants, complicating acute upper respiratory infections, pertussis and measles; 20 were in adults. The results were equivocal and difficult to evaluate. Five cases in infants and 7 in adults recovered promptly by crisis, while 19 cases, not obviously benefitted by sulfapyridine, ran the expected course to recovery. Four cases died, two being infants with pneumococcic bacteremia (Types XIX and XXIII respectively), the other two adults, one post-operative, the other a Pn. Type VI infection in a patient dying of chronic glomerular nephritis.

Problems in the Use of Sulfapyridine

Some of the practical problems involved in sulfapyridine therapy are concerned with dosage, desirable duration of treatment, methods of administration of the drug, the variable degree of acetylation, and the immediate toxic and later untoward reactions encountered in a not inconsiderable number of patients.

Dosage.—The initial dose employed in adults in this series of patients has been either one dose of 2.0 gms. or 1.0 gm. q. h. for four doses. An appropriately smaller initial dose of 0.5-1.5 gms. was used in infants and children. This has been followed by 1.0 gm. q. 4 h. day and night in adults, 0.25-0.5 gms. q. 4 h. or q. 6 h. in infants and children, for three or four days. If recovery had occurred and no serious untoward reactions had developed, the dosage was then cut in half and continued for two or three more days.

The scheme of dosage outlined above has seemed therapeutically effective and has served to establish promptly in the majority of our patients a blood concentration of free sulfapyridine ranging between 5 and 10 mgm. per cent, as illustrated in Fig. 5. In approximately 20 per cent, however, the concentration remained under 5 mgm. per cent, while in a similar number it rose above 10 mgm. per cent by the second or third day. These variations in concentration of free sulfapyridine in the blood apparently showed no consistent relation to therapeutic effect. For example, in 40 early cases prompt critical recovery had occurred in 12 with a concentration of less than 5 mgm. per cent, a finding which has been noted by others. While it is apparent that some patients respond promptly and satisfactorily with relatively low blood concentrations, further experience is necessary to establish how frequently this will occur and whether the dosage that has commonly been used may be safely reduced.

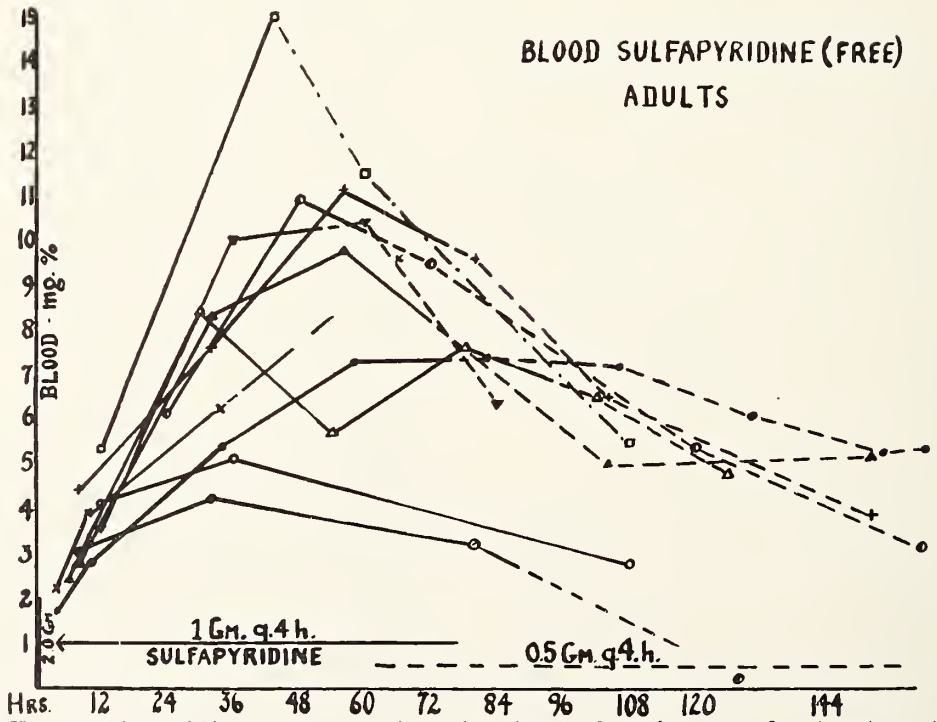

Figure V. Free sulfapyridine concentrations in blood of patients under treatment.

Duration of Treatment.—How long treatment should be continued in lobar pneumonia after the temperature has fallen to normal in order to prevent possible recurrence, re-

quires further study. In this series recurrences have been quite infrequent. In 48 cases of the group treated with sulfapyridine alone in which drug therapy was not carried beyond the eighth day of the disease, the relation between day of disease on which therapy was stopped and the occurrence of relapse was as follows:—

Sulfapyridine Stopped	Cases	Recurrence
3rd day of disease	4	0
4th " " "	6	1
5th " " "	6	0
6th " " "	10	1
7th " " "	10	1
8th " " "	12	1

Since permanent recovery probably depends upon the development of specific antibodies by the patient, it would seem desirable to continue treatment to the 7th to 9th days after onset of the pneumonia, provided no untoward reaction occurs which demands immediate cessation of treatment. Further experience may indicate, however, that this is unnecessarily long in the majority of patients.

Methods of Administration. — Although oral administration is the method of choice, this is often rendered difficult because of the frequency of severe nausea and vomiting attendant upon the use of sulfapyridine. Since this is probably in large part a central toxic effect, none of the various methods suggested for allaying local gastric irritation can be expected to be very useful, and they have proved quite futile in our experience. Consequently we have from the start resorted to parenteral administration of sulfapyridine when continued nausea and vomiting have interfered with adequate oral dosage. For this purpose 2.0 gms. of pure sulfapyridine powder dissolved in 1500 cc. of normal saline, in 1000 cc. of 5 per cent glucose solution, or in 500 cc. of 5 per cent glucose solution + 500 cc. of normal saline have been used.* These solutions were given by hypodermoclysis or intravenously without any local or general reactions. In general, two infusions or clyses daily containing 2.0 gms. each of sulfapyridine and given at approximately twelve-hour intervals have been found adequate for satisfactory therapeutic effect (Fig. 3).

While parenteral administration may not immediately check nausea and vomiting because of the central action of sulfapyridine, the procedure described above appears to possess several advantages in that the drug may be given either subcutaneously or intravenously, there is no danger of local tissue injury as there is with sodium sulfapyridine[10], and the method provides salt, glucose and water for patients who are much in need of them because of fever, persistent vomiting and inadequate intake. The method is also of value in stuporous or comatose patients.

Acetylation.—With any given dosage the two most obvious factors influencing blood concentration are variations in absorption and excretion of sulfapyridine[11]. A less obvious, but in our experience an equally, if not more important factor, is the rate and degree of conversion of free sulfapyridine to the acetyl derivative by the liver[12]. This may vary greatly and unpredictably from individual to individual over a wide range from 15 to 65 per cent or more as shown in Fig. 6.

* Details concerning the preparation of these solutions will be published elsewhere.

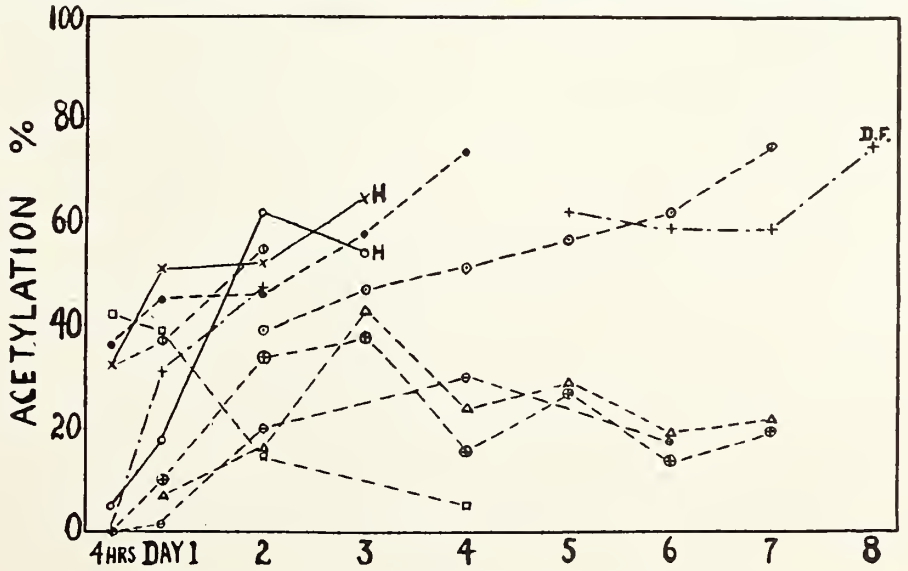

Figure VI. Course of acetylation in 10 cases. H. = hematuria. D.F. = drug fever.

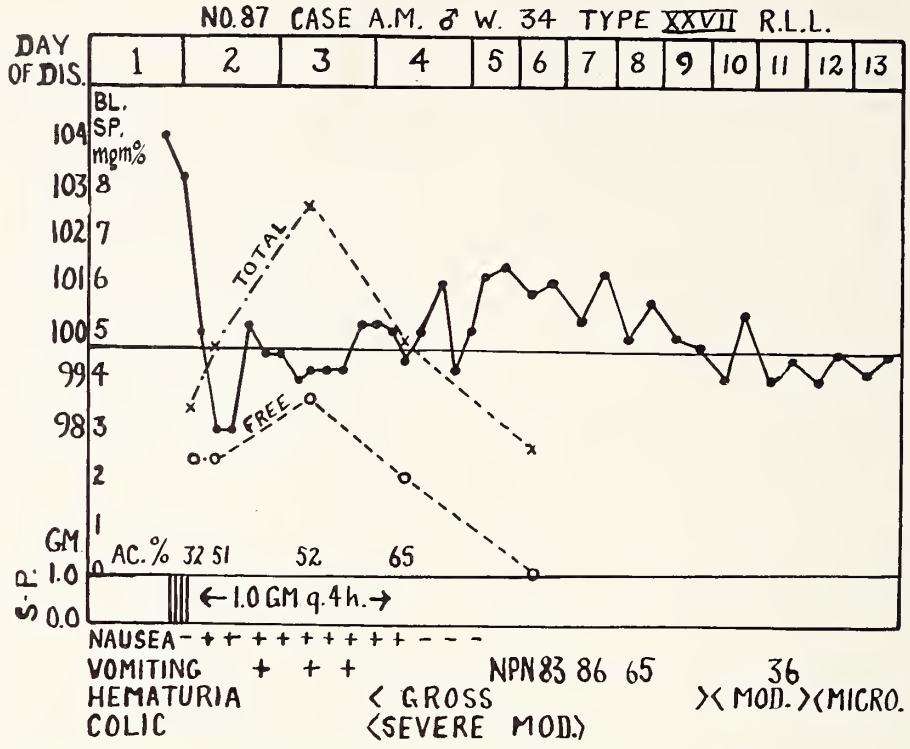

Figure VII. Hematuria complicating sulfapyridine therapy.

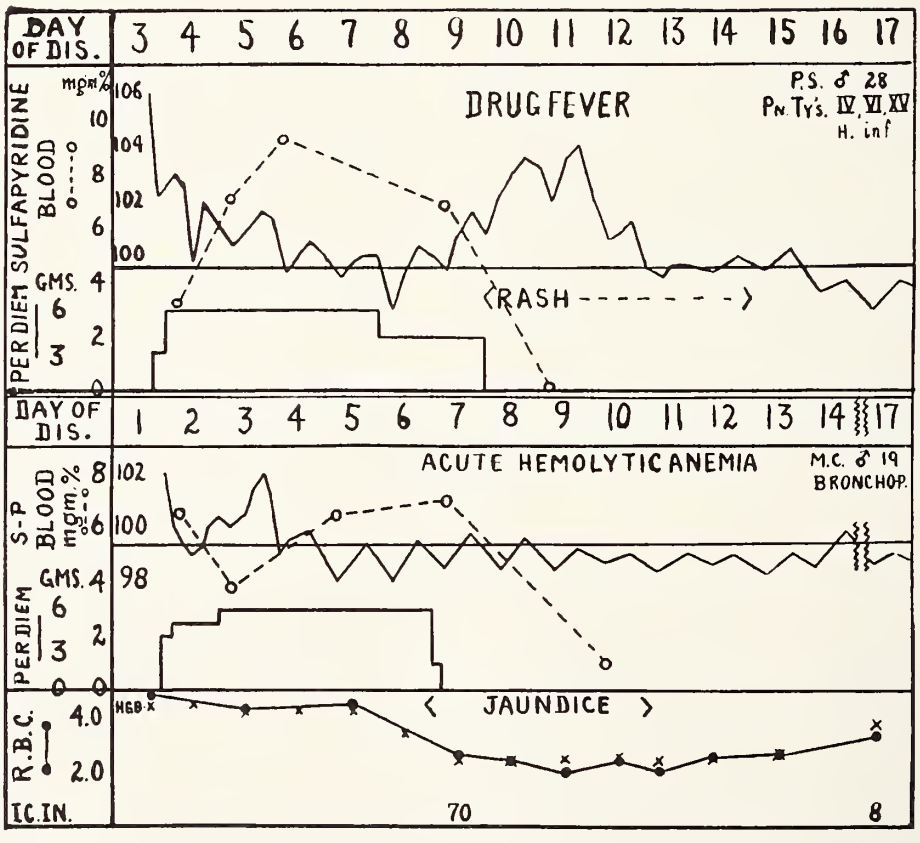

Figure VIII. Cases illustrating drug fever and acute hemolytic anemia.

The potential danger of a high degree of acetylation is well illustrated by Case 87, Fig. 7, with gross hematuria, severe renal colic, and temporary anuria, phenomena undoubtedly due to the deposit of the highly insoluble acetyl sulfapyridine crystals in the kidneys[13]. Because of this danger and in view of the fact that a low or falling free sulfapyridine concentration in the blood might be mistakenly regarded as an indication for increasing dosage, it has become our usual practice to determine both total and free sulfapyridine concentrations during the first few days of treatment as a guide to dosage. The incidence of hematuria will be referred to below.

Immediate Toxic Reactions.—The immediate toxic effects of sulfapyridine appear to be in general similar to those with sulfanilamide. During the first few days patients are frequently depressed or irritable. Dizziness and headache are not uncommon complaints. While some cyanosis is frequent, it is in our experience less noticeable than in patients being treated with sulfanilamide. No cases of clinically recognizable acidosis have occurred in this series.

The most frequent and distressing of the immediate toxic reactions are nausea and vomiting. In this series they have occurred to some extent in approximately 60 per cent of the patients, being quite severe in a third of these. They usually began within a short time after the initial dose and lasted for two to four days, when they ordinarily abated even though sulfapyridine was continued. The use of parenteral treatments to help meet this problem has been referred to.

Later Untoward Reactions.—The delayed reactions also appear to be similar to those encountered with sulfanilamide therapy, namely, drug fever, dermatitis, acute hemolytic anemia and granulocytopenia. These are now so familiar that they need not be described in detail. In this series, excluding the serum treated cases and those which died promptly after treatment was started, drug fever, usually with a maculopapular rash, occurred in 10 cases or approximately 9 per cent. There were two cases of acute hemolytic anemia and 4 of granulocytopenia. All of these patients recovered satisfactorily except one case of granulocytopenia in a woman of 61 with Paget's disease. This case, in whom neutropenia developed suddenly on the twenty-second day, progressed rapidly to a complete agranulocytosis with fatal outcome.

Acute hematuria, which has already been referred to, occurred in 9 cases. It began on the third day of treatment in 5, on the fourth day in 2, on the sixth day in 1 and on the seventh day in 1. In four cases it was merely microscopic and cleared up after two or three days. In 2 cases it was more severe with smoky urine, moderate abdominal pain and costovertebral tenderness, and slight fever. The duration of symptoms was five to six days. In 3 cases the reaction was very severe with grossly bloody urine, severe colic, and fever. In two of these there was temporary suppression of urine and retention of nonprotein nitrogen. With immediate cessation of sulfapyridine therapy and forced fluids all cases recovered. In five of these cases in which the figures are available the degree of acetylation ranged from 44 to 73 per cent, the blood concentration of acetyl sulfapyridine from 3.9 to 8.3 mgm. per cent shortly before or concomitantly with the onset of symptoms, yet there must be other factors involved in determining this reaction, since there were at least 12 other cases who had equally high concentration of acetyl sulfapyridine in the blood without developing hematuria. Further study of this problem is desirable.

Summary

Sulfapyridine appears to be an effective chemotherapeutic agent in pneumococcic lobar pneumonia, particularly in persons under sixty years of age. It is probably as effective in B-hemolytic streptococcic pneumonia as sulfanilamide, but unless it can be shown to be more effective, the latter should be preferred. No evidence has been obtained that sulfapyridine is of value in severe staphylococcic pneumonia nor does it appear to be conspicuously effective in bronchopneumonias of mixed and variable etiology, but further observations are desirable to define its possible usefulness in these types of pneumonia.

In view of the discomforts and hazards associated with sulfapyridine treatment and

its apparently variable efficacy in different etiological types of pneumonia, etiological diagnosis of pneumonia would appear essential for the proper selective use of sulfapyridine and the evaluation of its effectiveness.

Untoward reactions from sulfapyridine are quite frequent, sometimes serious. Because of these reactions patients being treated with sulfapyridine should be closely observed, blood counts and urinalyses should be done frequently and, when possible, the concentration of free and total sulfapyridine in the blood should be determined as a guide to dosage, at least during the first three or four days of treatment and at intervals thereafter if treatment is prolonged. With the onset of any of the untoward reactions sulfapyridine should be stopped immediately, fluids should be forced and other appropriate measures employed as indicated.

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Discussion

Elton R. Blaisdell, M. D. (Portland): Mr. Chairman, Dr. Blake and Members of this Association: I am glad to say a few words concerning this kindly, most interesting and instructive paper on the Chemotherapy of Pneumonia; but I feel a good deal like Dr. Cox in discussing Dr. Moorhead's paper.

I don't think there is anything instructive I can add, therefore I am not going to take up very much of your time; certainly it is difficult to emphasize any part of this paper very much more than any other part, because it is all so instructive and contains such a large amount of good material, and shows a great deal of work on Dr. Blake's part.

I think perhaps he has been rather modest in not drawing up very many conclusions on his paper, because certainly this is an extremely well worked-up paper. During the past few months I have heard two or three papers on this subject and this is truly one of the best, and I believe the best paper I have heard, and worked up in the most interesting way. It is very difficult, of course, to present a paper of this kind because there are so many new things coming up all the time.

Dr. Blake has brought up two or three things today in his paper that we haven't heard about before. I would like to emphasize two or three things. One is the question of the toxic conditions that do appear in the blood and in the urine following sulfapyridine therapy, and this question of differentiation between the total and free sulfapyridine in the blood certainly is of extreme importance.

Dr. Blake has brought out the important thing that some of these patients in whom we should have cut the drug down, perhaps we may increase the drug which caused the total sulfapyridine to

ascend apparently up to the theoretical therapeutic level. Therefore, instead of cutting it down as we should, we increase it. I think it is of extreme importance to do both the total and the free blood sulfapyridine.

Now there is another very important thing, and that is the question of use of sulfapyridine in the home or away from the hospital. That is the only other thing that I did want to bring up this afternoon, the only thing that I could perhaps add. It really isn't an addition; it is more in the manner of a question that I would like to ask Dr. Blake in behalf of our rural physicians. This question is freely asked: Is it safe to use sulfapyridine in the home?

Now partly as the result of the increased existence of illness during the winter months, and partly as the result of the new hospital insurance with much of it, a few patients now enter our hospitals for treatment of trivial complaints; and often many patients living in our cities find it difficult to get—even many patients living in our cities find it difficult to get hospital accommodations; therefore it seems that if sulfapyridine is going to be used, I mean if it is going to be an extremely practical drug, we must have some method whereby the physicians living away from the hospital and having to treat patients outside the hospital, especially out in the rural communities, can do something about it.

I think myself it is a very important thing. It isn't always easy to get the blood into the hospital. Dr. Blake may know of some method, some shortcut method, perhaps, that the country practitioners can use so that they can use sulfapyridine. As I say, certainly one can't add anything to this wonderful paper. Thank you.

Doctor Blake: Dr. Blaisdell, of course, has raised a very important question as to whether it is safe to use sulfapyridine in the home, and particularly under conditions, and I realize there must be many, in which it is not possible to get prompt determination either of the free or the total sulfapyridine levels in the blood.

I think that without having had experience in using the drug in the home, as I have used it only in the hospital, I would take the view that in true lobar pneumonia cases, sulfapyridine is undoubtedly a real curative agent and that the physician would be justified, in the present state of our knowledge, in using the sulfapyridine in the home under these circumstances.

I know of no tricks by which one can guess the measure of sulfapyridine level in the blood apart from the actual chemical determination. Now if one is to treat patients without the benefit of chemical determinations of the level of the drug in the blood, it seems to me there are two important things:

First, there is his complete familiarity with the usual clinical manifestations of toxic reactions. These are difficult to describe, and one learns to recognize them more and more, of course, by experience in seeing them. Now what are these? Acute hemolytic anemia can, of course, be detected by laboratory examinations of the blood. But suppose these are not available?

Obviously the first indication of hemolytic anemia is the icterus; so that in any patient under treatment for pneumonia with sulfapyridine, it seems to me essential that the physician never forget every time he sees his patient to look at the sclerae and if there is any icterus, the drug should immediately be stopped. I believe this should be done at least twice a day during the first week of sulfapyridine therapy.

So far as the hematuria is concerned, one has to be carefully on the lookout for that. And that is not difficult, of course, for any of you if you are willing to collect and can collect a specimen of urine each time you visit the patient, or let somebody in the family save it. Simply make an examination of the specimen to see if there are red cells which may be a warning of the hematuria to come; and if red cells appear in the urine, immediately stop the drug and force fluid.

Also with respect to the hematuria, the more severe attacks may develop suddenly. They often do with our patients, right in the middle of the night, and we see that the patient is complaining of severe pain in the abdomen and the back. Then the mistake that occasionally has been made has been to interpret that as an increase in the pleurisy rather than the first sign or symptom of renal colic.

So that any complaint of abdominal pain on the part of the patient under sulfapyridine therapy, demands immediate stopping of the drug and then examination as soon as possible to see whether this may be due to a newly developing hematuria.

I meant to have emphasized more the question of fever in relation to relapse, because that presents another difficult clinical problem. If the temperature has come down promptly, as illustrated in the chart, and has been normal for three or four or five days, you usually stop sulfapyridine. If the temperature shoots up to 102 or 103 or 104, you are confronted then with the decision as to whether that fever is a drug fever which occurs in about 10 per cent of the patients, or whether it is a relapse of the infection.

Now we have taken the view under those circumstances when, after a period of normal temperature, the temperature suddenly rises again, that unless we can prove to our satisfaction that it is an extension of the infection, we stop sulfapyridine until we know, because if one begins to give sulfapyridine again or increases the dosage at the beginning of the drug fever, one may precipitate the patient into a severe febrile illness.

So the first appearance of icterus in the sclerae, any abdominal pain, any red cells in the urine, or any unexplained rise in the temperature after the temperature has been normal, should be an indication to stop the drug if it hasn't already been stopped, and certainly not to increase the dosage until you are sure of the situation.

*General Management of the Injured**

By John J. Moorhead, M. D., F. A. C. S.

(Professor of Clinical Surgery, New York Post-Graduate Medical School)

In every branch of surgery there are certain axiomatic vital clinical facts, definite conclusions, identical experiences, parallel deductions. These rate almost as infallibles, they virtually constitute our creed, they are guide posts to diagnosis, treatment and prognosis. Strangely enough in traumatic surgery, the most ancient of all forms of surgery, we are still in disagreement as to some of the basic essentials, especially as to traumatotherapy, the treatment of the injured.

A survey of the traumapathies brings the realization that 80 per cent of the lesions encountered comprise: (1) wounds, (2) burns, (3) fractures, (4) joint injuries, such as sprains, synovitis and dislocations. If we thus visualize and delimit this field of traumatic surgery and focus our attention thereon, we may attempt a survey with a view to collating a series of non-controversial precepts that may be helpful in clarifying a somewhat foggy vista.

With this as an outline, I bring to your attention certain precepts in the general management of the injured.

(1) Wounds

(a) Every wound not made with surgical intent is already infected, and the main problem is, therefore, the treatment of *infected wounds.*

(b) There are only two methods of sterilizing any wound; namely, by mechanical, or by chemical means. We adopt mechanical means when we cleanse with soap and water, and follow if necessary by non-sacrificial *débridement.* We adopt chemical means when we apply to the wound some antiseptic. As to these, we must remember that proper mechanical cleansing is the basic preliminary, and we cannot rely solely on any vaunted antiseptic, despite propaganda, colourful appearance or clever advertising. Abundant experience has shown that any antiseptic capable of killing organisms *in vivo* also kills the tissues, and thereby renders inert the very inherent qualities we seek to promote and protect. In every age there has been a grand hurrah as to some "new antiseptic" guaranteed to solve this problem of wound infection. Just now we are passing through a phase in which gaudy colours are the vogue, and we are importuned gaily to paint or daub our wounds because the present style of organisms prefer more sombre shades than did their predecessors. This is chromatic rather than traumatic surgery, and has no real or lasting basis.

(c) Drainage is important in accidental wounds, and gauze should not be used because it soon acts as a plug. Taxidermy is not good surgery.

(d) Delayed or primo-secondary suturing is a safety-first principle which should be more diligently practised, especially in stripping-up or contused lacerated wounds. Hence, after cleansing, we place but do not tie the sutures until the end of the second or third day, in the interval covering the wound with a gauze dressing soaked in some proven antiseptic. Our personal routine choice is one dram of the tincture of iodine to one pint of normal saline solution (referred to as "I. S. solution"). Probably sterile gauze would do just as well if the wound has been properly cleansed, the blood clot removed and the frayed edges excised.

(e) Tetanus antitoxin should be used whenever soil contamination so indicates, and in all gunshot wounds. If given slowly in saline solution dilution there will be little anaphylactic reaction. Combined sera, such as anti-tetanic and anti-gas-gangrene, are as yet insufficiently standardized to enter the precept class.

* Read at the 87th Annual Session of the Maine Medical Association, Poland Spring, Maine, June 27, 1939.

Sulphanilamide and its derivatives appears to have a place in the treatment of infected wounds and should be given a trial in carefully-selected cases. However, let me warn that the after-effects of this form of chemo-therapy are still unknown.

(f) Rest, elevation, splintage and infrequent dressings are a quartet rendering wound healing more melodious and less malodorous.

(g) Infection occurring within the first three days is probably primarily due to the initiating trauma; occurring thereafter it is probably secondarily due to reinfection from imperfect initial cleansing or introduced infection from too zealous or improper dressings. The life-cycle of the usual pus-producing organisms averages three days, so that the onset of infection with this known period of incubation should not be difficult to determine.

(h) Operations for infected wounds should be postponed until there are focal manifestations, such as local fluctuation, tenderness or induration. This focalization is aided and abetted by the use of hot wet gauze dressings, moistened in saline or magnesium sulphate solution, kept hot by an electric bulb, and kept moist by a perforated rubber tube inserted between the many-layered gauze dressing. This to be sure is like the old-fashioned poultice; but it does focalize, and it is efficient. No incising is in order for generalized swelling, redness or induration (cellulitis); and above all, interference is inadvisable for lymphangitis and lymphadenitis, especially along the pathway of red streaks.

When incision is decided upon, let it be deep enough and long enough to provide self-gaping so that self-drainage will occur without the necessity for gauze packing. If gauze is used for hemostasis or ballooning purposes, let it be lubricated with vaseline or albolene so that it will not become adherent. An ordinary rubber band or a sectioned rubber glove will make an excellent drain; if a stiffer drain is needed, as in a pocket, a pipe-cleaner will be useful.

(i) Secondary suture will cut short a long granulation period in many wounds; likewise, pinch-grafts are quite effective for the same purpose. Both procedures are often local anesthesia procedures, using novocaine (1-2 per cent) or an equivalent, with or without a preliminary dose of luminal (1-5 grains) or morphine ($\frac{1}{6}$-$\frac{1}{2}$ grain).

(2) Burns

The thermal effect is the essential, and in reality, every burn can be regarded as a wound of thermal, chemical, radiation or electric origin, irrespective of the source.

(a) Pain is relieved by morphine or an ally, and some anodyne should be a routine of treatment.

(b) Dressings of sodium bicarbonate (5-10 per cent solution) are applied at once, and a perforated rubber tube is enmeshed in the dressing so that re-moistening is accomplished without replacement of the original dressings. Some surgeons, however, prefer to use tannic acid.

After two to three days, the stage of *dermatitis* is followed by the stage of *secretion,* and now the part is exposed to the open air or to an electric bulb (60-100 watts) for increasingly long periods. In the intervals of this exposure séance, the area is covered by gauze, soaked in vaseline, albolene, or equal parts of sterile olive oil and camphorated oil.

When the third or *cicatrizing* stage is reached, the exposure is practically continuous, especially if the area is covered by a wire mesh or some other form of glorified "vaccination shield" device. We use "Celoglas" for this purpose because the violet rays are not intercepted; this material is a narrow wire mesh impregnated with acetone-cellulose and is used by chicken fanciers as a substitute for glass. Tannic acid (3-5 per cent) is used as stated by those who prefer to obtain a chemical *débridement* or tanning effect; but to be effective, it should be employed from the outset and the surface must be oil-free.

(c) *Débridement* should be reserved for selected burns under selected conditions, preferably localized third degree burns.

(d) Contractures are anticipated, and hence, by posture and exercises, every effort is made to prevent their occurrence, notably

in such regions as the neck, axilla, elbow, groin and knee.

(e) Forcing fluids, especially in children, is an important element of treatment.

(f) Skin grafting and plastics should be early rather than late phases of treatment when the circumstances permit.

(3) Fractures

(a) Bones are the shaped equivalents of soft parts, rendered thus by calcium and other elements.

(b) A fracture is a wound of bone, and as in other wounds, there are two general groups or types. A type I fracture is one in which the bone edges are not end-to-end, due to overlapping. A type II fracture is one in which the bone edges are end-to-end, and there is no overlapping. Either of these may be simple (closed) or compound (open), and the direction of the fracture lines may be transverse, oblique or alphabetical. Obviously, a type I fracture corresponds to a lacerated, and a type II fracture, to an incised wound.

(c) The essential object in treatment is to convert a type I (overlapping) into a type II (non-overlapping) fracture; in other words, our side-to-side anastomosis is to be converted into an end-to-end anastomosis.

(d) Traction and manipulation are the essentials and there are only two available methods at our disposal; one is manual, the other mechanical.

(e) Early reduction means easy reduction, and if we realign within the first few hours we are treating the fracture alone; if thereafter, we are treating the fracture plus complications.

(f) "Secondary swelling" is an index of circulatory stasis, due more often to delay than to the original trauma; hence, it is not a necessary but an avoidable evil.

(g) Provisional traction is always applicable, and we should adopt some simple means of providing this during the waiting period between our first visit and the time of definitive setting. This means that in the hospital or the home we should at once attach to the ankle or the wrist some traction device that will effectively prevent muscular contraction during an enforced waiting period. A sheet or towel fastened to the ankle or wrist is a simple device, and if now the limb is placed on a pillow and the foot of the bed elevated, it only remains to attach a weight to the sheet or towel, and thus we have applied the principle of traction and counter-traction. In hospital, a boot or gaiter, adhesive straps or a glued sock may be substituted; but the point is that *some* sort of traction is applicable, even amid the most desolate or destitute surroundings. Overnight traction of this sort usually will convert a type I (overlapping) into a type II (non-overlapping) fracture.

(h) X-ray examinations should be used more for the purpose of proving the success of setting than for the purpose of proving the success of diagnosis. We are rapidly losing our special sense organs from disuse, and assuredly by inspection and palpation we should be able to diagnose a bony from a non-bony enlargement in the vast majority of injuries. Prior to 1895, X-ray diagnosis was unknown, and yet our predecessors did a pretty good job in the average fracture, even though automobiles and aviation have introduced a much more varied type of tranmapathy.

(i) In any recent joint injury associated with deformity and disability, suspect fracture and not dislocation in 80 per cent, the shoulder alone excepted.

(j) In a type I (overlapping) fracture the diagnosis is made by the sense of sight almost invariably, the presence of bony deformity being the main feature. Dislocation should be the only confusing factor.

(k) In a type II (non-overlapping) fracture the diagnosis is made by the sense of touch almost invariably, the absence of bony deformity being the main factor. Contusion-sprain is to be differentiated, and in this the pain is anywhere and everywhere; in a non-displaced fracture it is just there and right there. In a type II fracture it is focal and local; in a contusion-sprain it is general and vocal.

(l) In the fracture lexicon there are four R's on the road to fracture knowledge, and these are: (1) Recognition or diagnosis, (2) Reduction or setting, (3) Retention or splinting, (4) Refunctioning or rehabilitating.

(m) Splints should be safe and they should be simple, and no splint however elaborate can do more than hold the fracture in position; hence, it is supreme folly to apply permanent splintage before resorting to setting. Every splint should fit the patient, and not the patient the splint.

(n) Moulded two-piece plaster of Paris splints have a very wide range of usefulness, and should be more often employed. They enhance circulation, they are removable for inspection and physiotherapy, they are custom made, they can be used from start to finish.

(o) Walking calipers (leg irons) permit earlier ambulation and shorten the crutch-bearing and disability period.

(p) Splints are removed in part when the stage of firm (lead pipe) union is reached, and they are discarded when the stage of solid (iron pipe) union is reached. This means that the calendar is not the index, but that the condition of callus repair is the proper guide, realizing that Nature's cement (callus) is a variable factor as to production and as to consolidation. Splints should not be used indefinitely, otherwise it often takes as long to recover from the treatment as from the fracture.

(q) Usage is permitted when certain "tests" produce no reaction in terms of prolonged pain, heat, swelling or redness. Forcible massage and resistive exercises are the essence of these "tests," and here again the condition and not the calendar is the best guide.

(r) Rehabilitation by massage, motion and exercises should be a coincident and not a late feature of treatment; hence, physiotherapy should not be a phase of "after-care," but in reality a part of concurrent care.

(s) Compound fractures should very rarely be treated by primary suture, but on the contrary primo-secondary or delayed suture (as described above for "wounds") should be practically routine.

(t) The use of metallic suture material in fracture surgery should be reserved for selected cases under selected auspices; and indeed bone surgery, like soft part surgery, has already entered the stage where non-absorbable material is rarely necessary or advisable.

(4) Joint Injuries

In all of these, early rather than late motion best promotes recovery. Hence, the attack is mobilization rather than immobilization; open warfare rather than trench warfare.

Sprains.—At the outset, alternate soaks of hot and cold water, followed by massage and suitable strapping and immediate usage, often permit the patient to resume the usual occupation at once. In the intermediate or late stage, the use of hot soap suds compresses, followed by massage with warm camphorated oil, followed by exposure to the heat and light rays from electric bulbs, is an excellent procedure. This is so routine with us in joint, muscle and tendon injuries that we refer to it as "SOL": S for soap, O for oil and L for light, each act of the triad to be used for ten minutes twice daily or oftener.

Synovitis.—We believe in immediate aspiration, thereafter continuing the treatment as for a sprain. In the knee we visualize the joint as the face of a clock, the XII mark on top center, the VI mark at bottom center. To aspirate, we paint the joint with iodine at the outer margin and then use a local anesthetic over an area about one inch in diameter. In the right knee we enter the aspirating needle (with a caliber the size of the lead in a pencil) at IX, and pass to XII. In the left knee we pass from III to XII. After all the available fluid is withdrawn (and it usually is blood) we seal the puncture with sterile adhesive or collodion, and strap the articulation with adhesive, purposely not encircling completely lest circulation be interfered with. Thereafter walking is permitted, and daily use of the "SOL" treatment is prescribed. In

football injuries and the like, we have found this method exceptionally efficient. Recurrent synovitis, especially from indirect violence, often is an index of intrinsic involvement, such as cartilage injury or some other form of joint calculus (fat pads, hypertrophied synovial tabs or osteochondritis dissecans, for example). Obviously, such a repeated sequence may require arthrotomy, and for this we prefer a large medio-lateral incision rather than a small sub-patellar incision.

Dislocations.—As in fractures, early replacement means easy replacement and hence, immediate treatment should be given. If for any reason this is inadvisable or inappropriate, provisional traction is a feature of value, just as it is in fractures. Dressings should not cause constriction, for after the dislocation is reduced, we are in effect treating a residual arthro-synovitis and capsule laceration.

Anesthesia

Anesthetics should be more freely employed when pain is present and when relaxation is desired. The safest anesthetic is nitrous oxide, and the most unsafe is chloroform. Ether by the drop method is very satisfactory. The intravenous anesthetics of the Evipal class I have found extremely useful and where a short anesthesia is desired, this group is especially useful in the treatment of the injured.

Physiotherapy following trauma should be a coincident and not a late feature. The best form of physiotherapy is self-use, and it is extremely unwise to permit the patient to get into the habit of relying upon any form of physiotherapy as a substitute for self-aid. Voluntary motion and set exercises are valuable measures and should be made a routine from the beginning of treatment.

Finally, let us remember that in traumatic surgery there are three S's—first, safety; second, simplicity; and third, serviceability. In traumatotherapy we are passing through a gadget stage in which many medical magazines carry illustrations suggestive of the latest issue of *Popular Mechanics*. However, this should not dismay us because every form of surgery has passed through exactly the same type of growing pains. A good carpenter can do a fairly good job with a few tools; fancy tackle does not catch the big fish and the best results are obtained by the skilled hand casting the right bait in the placid pools of experience.

The Ten Commandments of Traumatic Surgery

I. Thou shalt have no god of trauma other than the welfare of thy patient.

II. Thou shalt not bow down to any graven image except Knowledge and Experience.

III. Thou shalt not take in vain the name of those who diligently seek the welfare of thy patient.

IV. Remember to give thy patient rest on the days following injury.

V. Honour the parents of traumatic surgery who gave birth to and practised this branch of general surgery.

VI. Thou shalt not kill thy patient by neglect nor by the practise of alien doctrines.

VII. Thou shalt not commit adultery by performing clinical crimes which may conceive such offspring as infection, deformity and disability.

VIII. Thou shalt not steal the ideas of thy brother practitioners without due recognition.

IX. Thou shalt not bear false witness against thy brother practitioners who probably did just as you would have done.

X. Thou shalt not covet thy fellow-practitioner's skill, his equipment, his hospital, nor anything else that is his, except his example, his knowledge and his experience.

Discussion

William V. Cox, M. D. (Lewiston): Mr. President and members of the Society: I think we have

Continued on page 307

*Urologic Diagnosis**

By Roderick L. Huntress, M. D., Portland, Maine

The development of urology has been one of the most interesting chapters in all medicine. Through the genius of the pioneers, some dead, others still alive, it has risen from the quackery of the uroscopist to become one of the most, if not the most, scientific branches of medicine. Literally and figuratively, with the coming of the cystoscope, light replaced darkness.

The development of urology has been a distinct progressive advancement, both in the plane of medical esteem and scientific attainment, which has met with a gratifying recognition both by the general public and the medical profession. Beginning with a group of men who from either choice or necessity limited their work to venereal problems, it has progressed through individual foresight and by the gradual but steady application of scientific genius to the present-day elevated status, where urology is second to no other branch of the medical field.

To be a good urologist, the greatest need is curiosity. Our predecessors have developed ways and means to find out almost anything about the genito-urinary tract. It is simply going through the routine that brings out the desired information. Thoroughness is the whole story, nothing is too small to neglect, and the whole diagnosis may become most evident from the s m of the small parts. All can be seen with the eye or by X-ray, and function can be determined about as accurately. Look, with naked eye and microscope, feel with finger and instrument, and you have the diagnosis.

Pitfalls in urology are ever present, as in the case of any medical specialty. Much can be learned from the men who have had great experience in the field of general practice. Narrowing of vision by constant application to a limited field must be avoided by the successful urologist, and only by close association and frequent consultation with men familiar with the patient or well read in other branches of medicine is it possible to arrive at a satisfactory diagnosis. Having a diagnosis established various problems of management again present questions about which all the knowledge available may be required. Avoidance of routine handling of cases will give the best results. The first, last and best course to pursue is "Individualize the patient." Generalization in the presentation of a subject of this sort is in my opinion very apt to leave one's listeners with a hazy impression of the field. Specific cases, discussed by all, with a free interchange of opinion may leave more of value, so for today's program I have picked out a few not too unusual cases for your consideration:

Case No. 1

MGH No. 55801. April 19, 1938. EL female, 51 yrs. Improved. T. B. cystitis, T. B. left kidney and ureter with autonephrectomy, T. B. right kidney and ureter.

C. C.: Great frequency of urination.

P. I.: Twenty years ago patient began to have frequency of urination and blood in the urine. She was treated medically with not much relief. A year ago she was cystoscoped and it was found that the left ureter could not be catheterized. The bladder was very much inflamed. T. B. bacilli found in the urine from the right kidney. The right ureter was dilated at this time. In November, 1937, the right ureter again dilated. The frequency of urination has been getting steadily worse and the patient dribbles much of the time. There is a great deal of burning with urination and the bladder region is very painful. There is a great deal of severe pain in the right loin which radiates down to the vulva. Also a lot of indigestion, gas in the bowels and constipation.

P. H.: Had one child 33 years ago. Appendectomy and pelvic operation three years ago.

* Read before the Somerset County Medical Society at Lakewood, August 24, 1939.

P. E.: Well-developed and well-nourished woman. Head normal. Heart: normal rate and rhythm. No murmurs, no failure. Lungs: no rales or dullness. Normal breath sounds. B. P. 120/84. Extremities: normal. Reflexes: normal. Right kidney palpable and tender. Left kidney not palpable. Tender supra-pubically over the bladder. No other masses or tenderness. *Cystoscopy:* April 20. Under 75 mgs. of spinal anesthesia, cystoscope introduced easily. Bladder specimen taken. Bladder washed out—fairly cloudy. Filled with 100 c.c. and inspected. The whole bladder very red. Two ulcers in the upper portion—the dome. Right ureteral orifice normally placed, only could be catheterized 2 cm. Left ureteral orifice not seen, but a small dimple seen in the scar tissue which is probably where the orifice was. 5 c.c. indigocarmine injected into vein but no appearance on either side in fourteen minutes. Cystoscope withdrawn.

Laboratory: April 20. T. B. bacilli found in urine from the right kidney. *Blood:* Hgb. 73%; RBC 3,670,000; WBC 7,700; neutrophils 68%; eosinophils 1.5%; basophils 1.5%; lymphocytes 27%; monocytes 2%. *Urea nitrogen:* 30. *Blood sugar:* 105. *Hinton and Kahn:* negative.

Case No. 1 E. L. Intravenous

Case No. 1 E. L. Intravenous

X-ray: April 22. Intravenous pyelogram: films taken 20 and 35 minutes after the injection show that there is no injection on the left side. Kidney outline on the left side is not seen. On the right side there is marked dilatation of the ureter, with irregularity of the middle and superior calyces, one calyx projecting downward is filled and shows marked clubbing. The ureter is tortuous in its mid portion at the level of the fifth lumbar vertebra and beyond this point no definite injection is able to be seen. Impression: findings are those of pathology involving the right kidney, which is probably tuberculosis inasmuch as she has had tuberculosis of the left kidney. The tortuosity of the ureter may be due to a constrictive lesion in about the middle third. Chest plate shows no active inflammation.

Pre-operative Diagnosis: T. B. both kidneys, both ureters, and bladder.

Operation: Patient was tranferred to the Farrington Hospital on April 22, 1938, where I operated on her. Under spinal anesthesia, Gibson incision made on the right side. Ureter found easily, and delivered into the wound. About three inches above the bladder, the ureter was very firm and fibrous. Above this area the ureter was dilated to

about the size of the thumb. The ureter was seized with Allis forceps and ligated just above the stricture. Divided above and tied. The lower end of the ureter was treated with 95% carbolic acid and alcohol, and allowed to drop back into the pelvis. Upper end of the ureter was brought out thru the middle of the wound and the adventitia of the ureter was sutured to the fascia of the external oblique, leaving the ureter projecting beyond the skin one-half inch with no tension. A plain rubber drain placed at the severed end of the lower ureter. The fascia of the external oblique closed with No. 2 interrupted chromic catgut sutures. The skin was closed with equisetene. No. 24 soft rubber catheter placed up the ureter to the kidney pelvis and drained freely. (Ureterostomy, right.)

Post-operative Diagnosis: T. B. both kidneys, both ureters, and bladder.

Progress: Patient made an uneventful convalescence, temperature never going above 99. The wound healed well except a small area around the ureter which granulated in. The ureter sloughed off just external to the fascia of the external oblique. Plain rubber drain was removed on the eighth day. Patient's discomfort immediately disappeared and her blood urea nitrogen fell from 30 mg. before operation to 14 mg. two weeks after operation.

Follow-up: Two months after operation, patient was up and about. Felt well and had gained twenty pounds. Patient has to have catheter changed about every three weeks. She doesn't mind wearing a urinal because of the great relief she has experienced. Her urine is clear and contains very few pus cells. It has not been examined for bacteria. Patient advised to follow sanitorium treatment at home and is doing so.

Case No. 12

MGH No. 56729. June 21, 1938. CC male, 58 yrs. Carcinoma of the penis. Improved.

C. C.: Painful swelling on end of penis.

P. I.: Four months ago patient noticed a painful swelling on the end of penis which caused considerable difficulty in voiding and made his stream deviate. Severe burning on urination and some blood in the urine.

P. H.: Was injured in an explosion in 1903 and at this time there was a fracture of the left hip, right ankle, and the left eye was destroyed. No other serious injuries or illnesses.

P. E.: Well-developed and well-nourished man. Head normal. B. P. 132/98. Heart: regular rate and rhythm, no murmurs, slightly enlarged. Lungs: no rales or dullness. Abdomen: normal. No tenderness. Few enlarged glands in the right groin. None of the left. Kidneys not palpable or tender. Rectally the prostate is normal in size and consistency. External genitalia: scrotal contents normal. Prepuce redundant. Glans somewhat enlarged and ulcerated, about one-half the substance being gone. This erosion bleeds slightly on contact, and is grayish in color. It involves the mucous membrane of the prepuce to some extent and is surrounded by indurated tissue which feels almost as hard as cartilage.

Laboratory: June 22. *Urine:* cloudy, straw, acid, Sp. gr. 1.027; 25 mg. albumin, no sugar, acetone, diacetic, or bile; 15-20 WBC and clumps, few epithelial cells and bacteria. *Blood:* Hgb. 80%; RBC 4, 150,000; WBC 5,200; neutrophils 56%; eosinophils 2.5%; lymphocytes 36.5%; monocytes 5%. *Hinton and Kahn:* positive. *Urea Nitrogen:* 14.

Pre-operative Diagnosis: Epithelioma of the penis.

Operation Note: Because of his blood being positive for syphilis, a dark field was made of the lesion as it resembled a chancre in some ways. The dark field was negative. Under gas anesthesia on July 20, the penis was prepared and draped and a section taken from the lesion with a high frequency knife for biopsy. Report from the biopsy was epithelioma of the penis. Syphilologist advised no treatment for the syphilis except KI because of his age and no symptoms or signs of the disease. July 26. Nembutal grs. 1½ and morphine grs. ⅙. Under 150 mg. spinal novacain anesthesia patient prepared and

draped. Tourniquet placed around base of the penis. Incision made around the penis down to the corpora, one inch proximal to the growth. Corpora cavernosa cut thru 1½ cm. proximal to this incision after first suturing the dorsal arteries and veins. The corpus spongiosum incised obliquely ½ cm. distal to incision thru the corpora cavernosa. All bleeding controlled with ligatures after the removal of the tourniquet. Tunica albuginea sutured over open ends of corpora cavernosa with mattress sutures. Catheter inserted thru the urethra into the bladder. Plain rubber drain under skin. Skin closed with equisetene interrupted. Urethral mucous membrane sutured at four points to the skin. Catheter sutured in urethra with equisetene suture. As there were no glands palpable in the left groin and as the patient had syphilis which might interfere with healing, it was thought unwise to attempt a Young's radical operation of the glands. An incision vertical to Poupart's ligament was made in the right inguinal region and widely retracted. The inguinal and femoral glands and the glands at the root of the penis were removed with the subcutaneous fat and lymphatics en masse. All bleeding controlled with ligatures, a plain rubber drain coming out in the lower angle of the wound. Skin and subcutaneous tissue closed with interrupted equisetene.

Post-operative Diagnosis: Carcinoma of the penis.

Pathological Report: Well differentiated epidermoid carcinoma of the penis.

Final Diagnosis: Epidermoid carcinoma of the penis.

Progress: Patient had an uneventful convalescence, temperature the first three days going to 101 at times, but falling to 98.6 and staying there thereafter. The penis healed very quickly, the drains being taken out on the second day, and the catheter being removed on the seventh day. Wound dry and clean on the eighth day and stitches were removed. The wound in the right inguinal region healed more slowly being twenty days before it was dry and clean. Patient left the hospital on the twenty-second day voiding a good stream with no difficulty and no complaints.

Follow-up: Patient has not been heard from since discharge from the hospital.

Case No. 15

MGH No. 406. July 25, 1938. AS 47 yrs., female. Renal calculi, pyelonephritis of solitary right kidney. Recovered.

C. C.: Backache of five months' duration.

P. I.: Five months ago the patient fell off a chair and immediately afterwards had pain in the right side of the back just below the ribs. Since that time she has had a dull ache in this region, made worse by moving, stooping, and all forms of exertion. Pain doesn't radiate. X-rays taken by the family doctor showed a calculus in the region of the right kidney. No frequency, dysuria, hematuria, or colic. Day, 3-5; night, none.

P. H.: Usual childhood diseases. Left nephrectomy for "pus kidney" in 1918. No stones. Menopause five months ago. No injuries of importance.

P. E.: Well-developed and well-nourished female. Respiratory and cardiovascular systems normal. B. P. on admission was 112/84. Abdomen: oblique scar in left loin, soft, no masses. Extremities: bilateral hallux valgus. External genitalia: normal. Right kidney

Case No. 15 A. S. Plain Plate

Case No. 15 A. S. Pyelogrrm

palpable at the lower pole. Moves on respiration. Somewhat tender to palpation and fist percussion.

X-ray: July 27. Intravenous pyelogram: the stones on the region of the right renal pelvis have not changed. There are a few small shadows on the gall bladder having the appearance of gall stones. Fifteen minutes after intravenous injection of the dye, a film shows filling of the renal pelvis, calyces, and greater part of the ureter which appear normal.

Laboratory: July 26. *Urine:* cloudy, straw, acid, Sp. Gr. Q. N. S.; albumin 50 mgs., no sugar, acetone, bile, or diacetic; amorphous materials; RBC 4-6; WBC 100-200; occasional epithelial cells, two plus bacteria. Aug. 23. *Urine:* cloudy, straw, neutral, Sp. Gr. 1.008; no albumin, sugar, acetone, diacetic, or bile; amorphous urate crystals, no RBC; 2-5 WBC; two plus epithelial cells, and one plus bacteria. July 26. *Blood:* Hgb. 82%; RBC 4,120,000; WBC 6,650; neutrophils 54.5%; eosinophils 3.5%; lymphocytes 40%; monocytes 2%. *Hinton and Kahn:* negative. *Urea Nitrogen:* 12. Aug. 1. *Calcium:* 12. Aug. 13. *Calcium:* 10. *Phosphorus:* 4.4. July 27. *Urine culture:* negative.

Pre-operative Diagnosis: Right renal calculi, infected right kidney, intra-renal pelvis.

Pre-operative Treatment: Forced fluids.

Operation: July 28. Pre-operative medication—morphine grs. 1/6, atrophine grs. 1/150. Patient prepared and draped. Under ether anesthesia, the usual oblique kidney incision made in the right loin down to Gerota's fascia. Fascia opened. Kidney delivered. Pelvis entirely intra-renal. Incision in Broca's line over inferior calyx, after applying light rubber-covered clamp to pedicle to control bleeding. Fairly large stone removed from kidney pelvis and two smaller stones from the lowest minor calyx. A No. 20 F. Malecot catheter inserted into pelvis thru nephrostomy. Two pieces of muscle placed around tube in kidney wound and kidney closed around tube with mattress suture of ribbon gut. Two plain rubber drains. Wound closed in layers. Condition good.

Findings: Normal hypertrophied kidney. No peri-renal adhesions. One calculus in pelvis, two in lowest minor calyx.

Post-operative Diagnosis: Renal calculi, infected kidney, right.

Pathological Report: Calcium oxylate stones from the right kidney.

Final Diagnosis: Calcium oxylate calculi, pyelonephritis, right kidney.

Progress: Highest post-operative temperature was 100.6. Both drains were removed on the sixth day post-operative. Sutures out on the eleventh post-operative day. Up in a chair on the fifteenth day. Nephrostomy tube out on the twenty-eighth day. Temperature stayed normal from this time on. Wound dry and clean the thirty-fourth day. On the day after operation the patient passed 905 c.c. urine, mostly thru the nephrostomy tube. Urine output continued good throughout the hospital stay. On August 19, the urine showed 100-250 white cells and colon bacilli. Patient was given 10 grs. prontylin with one-half dram of sodium bicarbonate q.i.d. On August 23, the urine contained only 2-5 pus cells per field. Patient's condition was good at all times. Fluids were forced and the

patient was advised to take 4,000 c.c. a day. Discharged on September 6.

Follow-up: Patient was discharged on September 6 and returned to the offices two weeks later feeling fine with no complaints. Urine at this time contained no pus. Two weeks from this time the patient was working normally and there was no pus in the urine. No complaints. Wound solid. No muscular weakness.

Case No. 17

MGH No. 564. August 2, 1938. MM female, 44 yrs. Infected hydronephrosis, left. Recovered.

C. C.: Frequency of urination. Day 10-15. Night 4-6.

P. I.: Ever since childhood has had indefinite pains in the left side of the abdomen. At the age of 15 had an appendectomy thru a midline incision hoping to find cause for pain. For the past twenty years has not been able to sleep on her right side because it felt as if something was falling down into the abdomen. For a great many years has had very foul urine and frequency. This has been getting steadily worse. About a month ago this condition became extremely worse. Also had very severe left sciatica. Came to the hospital because she was getting progressively worse.

P. H.: Appendectomy at fifteen years of age. No serious injuries, or illnesses, except P. I.

P. E.: Head: normal. Heart: normal rate and rhythm, no murmurs. B. P. 110/60. Lungs show no rales or dullness. Abdomen: mass size of football in left loin. Vaginal consultant reports normal pelvis. Extremities: normal. *Cystoscopy:* Under Nupercain ointment urethral anesthesia, cystoscope introduced easily. Bladder specimen taken. Bladder tolerance 300 c.c Bladder inspected. No stones. tumors, ulcers, or diverticula seen. Ureteral orifices normally placed. Both catheterized with No. 5 French with moderate difficulty. No stasis on either side. Specimen taken from each side for smear and culture. No urine obtained from the left side. 5 c.c. indigocarmine injected into vein. Appearance time 8″ on right. Function good. No dye appearance on the left in 30″. Plain plate with catheters in and bilateral pyelograms made. Catheter and cystoscope withdrawn.

Laboratory: Urine culture on August 3, negative. *Blood:* Hgb. 75%; WBC 12,850; neutrophils 81%; eosinophils 2.0%; lymphocytes 13%; monocytes 4%. *Hinton and Kahn:* negative. *Cultures* from smears of the urethra and cervix negative for G. C.

Case No. 17 M. M. Pyelogram

X-ray: August 3, 1938. Genito-urinary, plain film with the catheters in position: the kidney outlines are indistinctly visualized on both sides. The catheter on the right extends up to the level of the 5th lumbar vertebra, that on the left up to the level of the 4th lumbar vertebra. No evidence of renal or ureteral calculi. *Pyelogram, bilateral:* Normal on the right side. On the left side there are rounded areas filled with the dye which involve the whole right upper quadrant and at this time the kidney outline can be visualized and is markedly enlarged, the dye filling only the dilated portions of the lower portion of the left kidney. Impression: findings are those of a hydronephrosis of marked

degree of the left kidney, with practically entire destruction of the left kidney.

Pre-operative Diagnosis: Infected hydronephrosis, left.

Operation: Under ether anesthesia patient prepared and draped. Usual oblique kidney incision made in the left loin. Incision carried down to kidney. Kidney delivered. Very large sac holding about 2½ quarts. Kidney emptied with trocar without spilling into wound. Ureter located, doubly clamped, tied, and cut. End treated with phenol and alcohol. Three clamps placed on renal pedicle. Pedicle cut between the two distal clamps. Pedicle doubly ligated. All bleeding controlled. Two plain rubber drains placed in kidney fossa. Wound closed in layers. Two SWG stay sutures.

Post-operative Diagnosis: Infected hydronephrosis, left.

Pathological Report: Hydronephrosis of left kidney. Kidney markings are lost and replaced by inflammatory tissue.

Final Diagnosis: Infected hydronephrosis, left.

Progress: Temperature at operation 102. Feeling well after the third day. Temperature fell until normal on the eighth day. Thereafter it did not go above normal. Moderate amount of drainage for eight days. Drains removed on the sixth day. Wound was dry and clean on the seventeenth day post-operative. Sciatica disappeared and has not recurred up till now.

Follow-up: Patient's wound is strong with no evidence of muscle weakness. She has now returned to her work as a school teacher.

Case No. 24

MGH No. 1093. September 1, 1938. GS male, 24 yrs. Torsion of spermatic cord, left. Recovered.

C. C.: Pain in left side of scrotum.

P. I.: Four days ago jumped off a wharf and felt a severe pain in the left testicle. Was nauseated and vomited. Testicle began to swell. Call M.D. who put hot packs on. Somewhat better the next day then testicle began to swell more than ever and was very painful. I was called in consultation the fourth day.

P. H.: No serious illnesses, operations, or injuries.

P. E.: Well-developed and well-nourished boy. Head normal. Heart: no murmurs, regular rate and rhythm. No failure. Lungs: no rales or dullness. Abdomen: no masses or tenderness. Kidneys not palpable. Penis and right side of scrotum normal. Left side of scrotum swollen three times its normal size. Skin dark and very much thickened. Contains a tumor which is extremely sensitive. Cord swollen to size of thumb up two inches from testicle and very sensitive. Epididymis could not be made out. No urethral discharge. Urine clear. No pus. Prostate secretion contains no pus.

Pre-operative Diagnosis: Torsion of spermatic cord, left.

Operation: September 1, 1938. Morphine grs. 1/6. Nembutal grs. 1½. Under 100 mg. novocain spinal anesthesia patient prepared and draped. Incision made high in the left scrotum down to the cord, and the peripheral layer of the tunica vaginalis. Skin and subcutaneous tissue "porky" and very much thickened. Testicle delivered. Tunical vaginalis very dark blue. Tunica opened. Bloody fluid found in the hydrocele. Testicle and epididymis bluish-black with vessels of the cord thrombosed about 2½ inches up from the testicle. Cord clamped just above the thrombosis, tied and cut. Removed testicle and affected portions of the cord. Stump of the cord fastened to the fascia at external ring. Plain rubber drain thru stab would at bottom of the scrotum. Fascia closed with No. 1 chromic interrupted and skin with equisetene.

Post-operative Diagnosis: Torsion of spermatic cord, left.

Pathological: Some small congested and hemorrhagic areas in cord; bloody areas show necrotic and hemorrhagic remnants of tes-

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The President's Page

To the Members of the Maine Medical Association:

The most interesting thing in the world today is the European War.

What the United States may do is of the utmost importance to us.

We are neutral, but as President Roosevelt has well said, we cannot, and will not, refuse to recognize facts.

On one side we cannot help seeing regimes characterized by bloody purges of political opponents; by broken promises and agreements; by heartless persecution of innocent people on the idiotic ground of racial difference; by an apparent reversion to barbarism, combined with modern scientific methods of destruction; and by a ruthless determination to dominate regardless of means or costs.

On the other side we see England and France.

It is true they have not paid what they owe us, but they have not shot the opposition members of Parliament, or confiscated the property of helpless groups of their own citizens; and they still believe in free thought, free speech, a free Press; and they have been good neighbors of ours.

They have some regard for their words and agreements.

They had to fight or submit to force.

Our sympathies and our interests are on the side of England and France.

The American people never were for peace at any price.

War is Hell—but there are things worse than war.

Perhaps one of them is to keep ourselves aloof while others fight and die for the things we believe in.

George L. Pratt, M. D.,
President Maine Medical Association.

Editorials

The Community Hospital as a Factor in the Betterment of Medical Service

A recent editorial in the *New York Times* has the following interesting statement: "For Senator Wagner it must be said that he introduced his Health Bill more as method of sounding public and medical opinion than as a project ready for legislative endorsement. . . . The public has reason to thank the Committee of Physicians for the Improvement of Medical Care for having patiently and thoroughly indicated where the bill is at fault and how it should be corrected." Without denying credit that belongs to the Committee of Physicians it might be pointed out that a reading of the record of the sub-committee of the Senate will definitely show that physicians holding official positions in the American Medical Association and some of its proponent State Associations pointed out with clarity and emphasis the many inherent dangers in the bill as it was drawn, its vagueness on many important points and the lack of need for the enactment of any such drastic legislation which is nothing more or less than an amendment to the Social Security Act of 1935 with the objective to make effective a national health program under direct government and bureaucratic control.

Agreeing with the contention of the Committee of Physicians that more hospitals are needed in *many* communities the *Times* feels that these hospitals should be open to all qualified physicians and surgeons. Just what way and how these qualifications are to be determined is not mentioned but the basic idea is one that should appeal to and interest all boards with appointive power to hospital staffs. Any community without adequate hospital facilities is unfortunate indeed, yet any hospital is as good and no better than the professional ability of those who comprise its staff, for the hospital today is the medical health and educational center of the community it serves; or should be.

Doubtless there are many communities that would like a hospital but the questions presenting to be answered; is there an actual need of one; can they support one, since the community must have a sufficient number of patients to warrant the cost and upkeep of a modern institution, and are there available skilled practitioners to properly staff it? Any hospital must serve its community well, it must strive in every way to serve it better with the advancement and demands of medical service, and while agreeing in principle with the statement that all qualified practitioners should be afforded hospital privileges any hospital must insist on its right to limit professional services to any member of the profession in the field which he is qualified by training and ability. Any board of trustees operating a hospital on a wide open door basis would soon find their troubles multiplied several fold.

There is no substitute for experience but experience today has passed the method of trial and error. Time and circumstances forced many men now in active practice to gain proficiency that way, but the younger members of the profession are not so unfortunately situated. Men graduating today from accredited services for internes are exactly the men that the community hospitals need and the men need them. They are not men of experience, except in a limited way, but working with, not under, their seniors in a properly conducted hospital offers the way that proficiency in skill and judgment can be obtained. The staff meetings of the smaller community hospitals, conducted not in a spirit of censorship but of attempting to profit by mistakes, have an educational value of great importance. The honest clinician learns and profits by his mistakes. They are sometimes embarrassing to admit, but admitted and discussed as they should be with interested members of the staff often point the way for others to obviate them much easier in the less formal and more cohesive smaller staff units.

The consideration before hospital boards must be is the one requesting the privileges an ethical and competent member of the profession. Hospitals have a right to insist on

such qualifications and the public no less. True it is that skill comes with experience and those honestly desiring it can and should obtain it in an environment insuring all possible safeguards and protection.

Harvey Cushing, M. D., 1869-1939

Born in Cleveland in 1869, Harvey Cushing died in New Haven, October 7th. Few men have been granted the honors bestowed on this famous physician, for such he called himself, since he felt that the differentiation between physician and surgeon was only on the basis of therapeutics and that "a surgeon is nothing if ignorant of medicine"; few indeed have merited them. Wonderful teacher, founder of the modern school of neurosurgery, a true lover of his fellowman, with unusual literary gifts, he left this world far, far richer and better for his being.

Honored at home and abroad by many governments and universities, truly it can be said that medicine has lost one of its truly great and humanity one of its greatest benefactors.

We can be justly proud that Harvey Cushing belonged to the profession of medicine and the United States. Those who were fortunate enough to know him must be truly grateful. The results of his benefits to humanity will be perpetuated and honored long, long after some whose lives and efforts have been devoted to destruction and death are nothing than a hazy memory; if even that.

Dr. Huntress—Continued from page 301

ticle, without inflammation, which apparently represent circulatory changes due to torsion of cord.

Final Diagnosis: Torsion of spermatic cord, left.

Progress: Patient had an uneventful convalescence, temperature falling to 99 and not going above. Patient's wound dry and clean on the seventh day. Drain had been removed on the third post-operative day. Stitches removed on the seventh day and the patient left the hospital.

Follow-up: Family physician saw the patient three weeks ago and found his wound dry and clean. Patient had no complaints.

The mental attitude of tuberculous patients is not one of optimism. In observing approximately 2,000 patients with tuberculosis, of whom 75 were closely studied, the prevailing moods were found to be depression, fatalism, anxiety and apprehension. It is recommended that extreme care be used in advising patients of the extent and nature of their disease and suggested that more attention be paid to the psychological care of those in tuberculosis hospitals.—Strecker, E. A., Braceland, F. J., and Gordon, B., *Mental Hygiene,* October, 1938.

Acute pleurisy with effusion should be considered as a case of potential tuberculosis unless some other cause for the condition is found. Observation should be continued for at least five years after the cessation of the actual pleural disease if the needlessly high mortality from pulmonary tuberculosis following sero-fibrinous pleurisy is to be avoided. From a public health standpoint the cases should receive the same repeated observations as a case of frank pulmonary tuberculosis.—Schneider, L., *British Jour. Tuber.,* April, 1939.

County News and Notes

Androscoggin

The first meeting of the year for the Androscoggin County Medical Society was an outing and dinner at Poland Spring on Tuesday, September 26th. Doctor R. N. Randall of Lewiston entertained with stories after dinner.

A meeting of the Androscoggin County Medical Society was held at the Auburn Y. M. C. A., October 12th. The State Crippled Children's Service presented a program with Doctor Hatt and Doctor Kobes as speakers.

W. P. Webber, *Secretary.*

Aroostook

The Fall meeting of the Aroostook County Medical Society was held at the Masonic Building, Mars Hill, October 10. Supper at 6.30. Program at 7.30. Doctor Garry Hough of the Shriner's Hospital in Springfield, Massachusetts spoke on *Common Congenital Deformities* and Doctor Allan Woodcock of Bangor spoke on *General Fracture Principles.* A business meeting given over to the discussion of medical care program of Farm Security Administration followed the scientific program.

T. G. Harvey, *Secretary.*

Cumberland

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, October 3, 1939, at 8.15 P. M. The President, Dr. E. E. O'Donnell, presided. There were 27 members and three guests present.

The Director of the Portland District Nursing Association, Velma Pettiner, spoke to the Club on *The Service and Problem of the District Nursing Association.*

Dr. T. M. Stevens presented a very comprehensive paper on *Pyelitis in Pregnancy.* The paper was discussed by Dr. H. L. Curtis, Dr. R. B. Moore, Dr. H. J. Everett and Dr. P. H. McCrum.

Alice Whittier, *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at Waterville, Maine, on Thursday, October 26, 1939, in conjunction with the Fall Clinical Session of the Maine Medical Association.

The afternoon program was under the auspices of the Maine Medical Association with clinics at the Thayer, Sisters and Elm City Hospitals and Central Maine Sanatorium.

Dinner at 6.30 P. M. at the Elmwood Hotel, which was followed by a business meeting.

Minutes of the last meeting were read and approved.

Pierre E. Provost, M. D., and Edmund E. Sawyer, M. D., both of Augusta, were elected to membership.

The application of Clarence J. Kenney, M. D., of Togus, Maine, was received and referred to the Board of Councillors.

George L. Pratt, M. D., President of the Maine Medical Association, Thomas A. Foster, M. D., President-Elect, and P. L. B. Ebbett, M. D., of Houlton, Chairman of the Council of the Maine Medical Association, were present and spoke briefly relative to the affairs of the Association.

The speaker of the evening was Elliott P. Joslin, M. D., Boston, whose subject was *Diabetes.* This was an extremely interesting address, most ably presented. He stated that the expectancy of life of patients having diabetes and being treated with insulin has been increased from 4½ to 20 years. Under the use of regular insulin there is always an enlargement of the liver; with Protamine Zinc Insulin the liver remains normal. The action of Protamine Zinc Insulin lasts 48 hours. As a rule, children born of diabetic mothers do not have diabetes; as far as he knows there have been only five or six children in the world born with diabetes.

There were 78 members and guests present.

Respectfully submitted,

Frederick R. Carter, M. D.,
Secretary.

Knox

A postponed meeting of the Knox County Medical Association was held at the Copper Kettle, Rockland, Tuesday, October 3, 1939.

Records of the last meeting were read and approved. John Kazutow, M. D., of Union, and Ralph P. Earle, M. D., of Vinalhaven, were elected to membership.

Doctor Francis McDonald of the Floating Hospital spoke on *Gastro-Intestinal Disturbances in Infancy.*

A. J. Fuller, *Secretary.*

Oxford

The annual meeting of the Oxford County Medical Society was held at Bethel Inn, Wednesday, October 25, 1939.

The officers for the ensuing year were elected:

President: William T. Rowe, M. D., Rumford.

Vice-President: C. W. Eastman, M. D., Canton.

Secretary-Treasurer: J. S. Sturtevant, M. D., Dixfield.

Auxiliary Committee on Legislation: D. M. Stewart, M. D., South Paris.

Delegates to Maine Medical Association: E. M. McCarty, M. D., Rumford; H. M. Howard, M. D., Rumford. Alternates: John A. Green, M. D., Rumford; R. E. Hubbard, M. D., Waterford.

Doctor L. C. Montgomery, Professor of Medicine, McGill University, Montreal, presented an excellent paper on *Pneumonia.*

J. S. Sturtevant, *Secretary.*

Penobscot

A meeting of the Penobscot County Medical Association was held on Tuesday, October 17th, with dinner at the Bangor House, followed by the evening meeting. Doctor Paul D. White of the Massachusetts General Hospital at Boston spoke on the general subject of *Heart Diseases*.

Piscataquis

The annual meeting of the Piscataquis County Medical Association was held at the Mayo Memorial Hospital in Dover-Foxcroft, September 28th, at 2.30 P. M.

The applications of John B. Curtis of Brownville Junction and John B. Valentine of Dover-Foxcroft were read.

The following officers were elected:

President: H. C. Bundy, Milo.

Vice-President: W. R. L. Hathaway, Milo.

Secretary-Treasurer: N. H. Nickerson, Greenville.

Delegate to 1940 Annual Session, Maine Medical Association: F. J. Pritham, Greenville Junction. Alternate: R. H. Marsh, Guilford.

Board of Censors: Ruth B. Thomas, Dover-Foxcroft; M. O. Brown, Dover-Foxcroft; W. E. MacDougal, Dover-Foxcroft.

Legislative Committee: W. R. L. Hathaway, Milo; Guy Dore, Guilford; M. O. Brown, Dover-Foxcroft.

Following the business meeting Doctor Charles Stanhope spoke on the activities of the State Department of Health and asked how it could be improved.

NORMAN H. NICKERSON, *Secretary.*

Somerset

The annual meeting of the Somerset County Medical Society was held at Lakewood Inn on August 24, 1939, with a good attendance both at the dinner and at the program and business meeting which followed.

We were fortunate in securing as speakers for this occasion, Doctor Huntress of Portland, whose subject was *Urological Diagnosis*, and Doctor Rosenthal of the Staff of the New England Medical Center, who spoke to us on *The Ambulatory Treatment of Diabetes*.

Both these men handled their subjects in a most interesting and comprehensive manner, and those who attended expressed their pleasure at being present at a most enlightening and interesting meeting.

The business meeting followed the scientific program. Two new members, passed upon by the board of censors, were voted into the Society, viz: Drs. Albert J. Bernard and Maurice S. Philbrick, both of Skowhegan.

The following officers were elected to serve for the coming year:

President: R. P. Laney, Skowhegan.

Vice-President: Howard L. Reed, Madison.

Secretary-Treasurer: Maurice E. Lord, Skowhegan.

Delegates to 1940 annual session, Maine Medical Association: R. P. Laney, Skowhegan, and H. L. Reed, Madison.

Board of Censors: W. H. Walters, Fairfield; E. D. Humphreys, Jackman; W. S. Milliken, Madison.

Program Committee: A. J. Stinchfield, Skowhegan; G. D. Sullivan, Bingham; A. J. Bernard, Skowhegan.

MAURICE E. LORD, *Secretary.*

York

The October quarterly meeting of the York County Medical Society was held on the 11th of October at the Hillcroft Inn, York Harbor, Maine.

At 1.00 P. M. a chicken pie dinner was enjoyed by all those present. At 2.00 P. M. the business meeting was opened by President Mayo. The report of the Secretary-Treasurer was read. It was voted to leave the program for the January meeting to the Secretary. It was also voted to send applications for membership to Doctor William Corbett, Kennebunk, and Doctor Belmont, Sanford.

Following the business meeting William J. Brickley, M. D., Medical Examiner for Suffolk County, was introduced as the guest speaker. Doctor Brickley began his talk with the History of the Medical Examiner and then branched off onto the various methods of discovering the causes of death, such as: chemicals, drugs, photography, finger printing, and microscopic findings. He referred to the fact that finger printing was the type of identification used on the Squalus victims.

There were twenty-two present. The twelve guests were:

William J. Brickley (Speaker), Boston, Mass.
Capt. W. J. Zalesky, M. D., U. S. N.
C. F. McGill, M. D., Portsmouth, N. H.
J. G. Bennett, M. D., Portsmouth, N. H.
James Sanders, M. D., Rye, N. H.
W. N. Petters, M. D., Portsmouth, N. H.
L. R. Whitaker, M. D., Portsmouth, N. H.
Belmont, M. D., Sanford.
Thomas B. Walker, M. D., Portsmouth, N. H.
Wallis D. Walker, M. D., Portsmouth, N. H.
William Corbett, M. D., Kennebunk.
F. S. Gray, M. D., Portsmouth, N. H.

Members present were:

A. J. Stimpson, M. D., Kennebunk.
E. C. Cook, M. D., York Village.
Ansel Davis, M. D., Sanford.
E. E. Shapleigh, M. D., Kittery.
Arthur Lamoureux, M. D., Sanford.
W. L. Morse, M. D., Springvale.
Carl E. Richards, M. D., Alfred.
S. A. Cobb, M. D., Sanford.
Dana B. Mayo, M. D., Eliot.
C. W. Kinghorn, M. D., Kittery.

C. W. KINGHORN, *Secretary.*

Coming Meetings

Kennebec

Kennebec County Medical Association, Frederick R. Carter, M. D., Augusta, Secretary.

November 16th, Gardiner General Hospital, Gardiner, Maine.

Speaker: Louis E. Phaneuf, M. D., Boston, Massachusetts.

December 21st, Augusta State Hospital, Augusta, Maine.

Speaker to be announced later.

Penobscot

Penobscot County Medical Association, Forrest B. Ames, M. D., Bangor, Secretary.

November 21st, Annual Meeting.

Speaker to be announced later.

New Members

Kennebec

Pierre E. Provost, M. D., Augusta, Maine.
Edmund E. Sawyer, M. D., Augusta, Maine.

Knox

Ralph P. Earle, M. D., Vinalhaven, Maine.
John Kazutow, M. D., Union, Maine.

Somerset

Albert J. Bernard, M. D., Skowhegan, Maine.
Maurice S. Philbrick, M. D., Skowhegan, Maine.

Change of Address

S. David Daniels, M. D.
From Central Maine General Hospital, Lewiston, Maine
To Western Maine Sanatorium, Hebron, Maine.

Anthony E. Peters, M. D.
From 66 Goff Street, Auburn, Maine
To 260 Aldrich Road, Portsmouth, New Hampshire.

C. E. Blaisdell, M. D.
From 27 State Street, Bangor, Maine
To 47 Broadway, Bangor, Maine

R. A. Goodwin, M. D.
From 16 Elm Street, Auburn, Maine
To 56 Dennison Street, Auburn, Maine.

Matthew T. Moorehead, M. D.
From U. S. Veterans Administration, Togus, Maine
To Graduate Medical School University of Pennsylvania, Philadelphia, Pennsylvania.

O. F. DeVeaux, M. D.
From 240 Brown Street, Westbrook, Maine
To 553 Lincoln Street, Manchester, New Hampshire.

Edward A. Greco, M. D.
From 16a Deering Street, Portland, Maine
To 12 Pine Street, Portland, Maine.

Notice

Clinical Conference

New England Society of Physical Medicine November 8, 9, 10, 1939

The New England Society of Physical Medicine will hold a Clinical Conference at the Hotel Kenmore, Boston, November 8 and 9, 1939, with a special session at Massachusetts Institute of Technology, November 10.

It will consist of clinical demonstrations and short talks on technique by some of the prominent practitioners in the field of physical medicine. Guest speakers will include Doctor Temple S. Fay of Philadelphia, who will discuss "Human Refrigeration"; Doctor Harold E. Himwich, of Albany, N. Y., who will talk on "Nitrogen Therapy in Schizophrenia"; Doctor Edward Edwards and Doctor Seibert Q. Duntley, who will present "The Pigments and Color of Living Human Skin." The principal speaker at the banquet on Wednesday evening will be Professor George E. Harrison, Director of Applied Physics Research Laboratory, Massachusetts Institute of Technology, whose address will be on "Modern Physics and the Modern Physician." Professor Harold Edgerton will present, "Seeing the Unseen by Stroboscopic."

For the special session at Massachusetts Institute of Technology the lecturers will be: Joseph W. Horton, Sc. D., Associate Professor of Biological Engineering; Arthur C. Hardy, Sc. D., Professor of Optics and Photography; Robley D. Evans, Ph. D., Associate Professor of Physics; John O. Trump, Sc. D., Assistant Professor of Electrical Engineering.

Dr. Moorhead—Continued from page 294

been very fortunate today to have Dr. Moorhead with us and to have heard such an interesting and complete paper on traumatic injury. And I feel in attempting to add to such discussion, and after such a fine sermon, it would be very much like trying to paint the lily.

There are a great many important points which we will all carry away with us, and I think that one of the most important ones is what Dr. Moorhead had to say in regard to treatment of trauma, particularly to the use of chemicals or solutions. Unfortunately many times great damage is done at the time of treatment by the use of chemicals which, as he has already said, do cause damage to tissues, in addition to causing damage to the organisms.

The second important thought along that line is the fact that what we do should always be directed to things which will help, and at least if they do not help will certainly do no harm. And all these points have been so well and so admirably brought out I feel there is really little left to be added. Thank you.

Necrologies

Oscar Rodney Emerson, M. D., 1872-1939

Doctor Oscar Rodney Emerson died at Newport, Maine, on September 25, 1939, following injuries received in an automobile accident.

Doctor Emerson was born in Plymouth, Maine, in 1872, the son of Charles and Mary Frances Emerson. He was a graduate of Bowdoin Medical School, class of 1894, later taking courses at Harvard Medical School and the Polytechnic Hospital in New York City.

He first started practice in Unity, moving later to Monson, and for the past thirty-five years has been practicing at Newport. Doctor Emerson was a member of the Penobscot County Medical Association, a member of the American Medical Association, and a member of the Maine Board of Registration of Medicine. He was also a 32nd degree Mason, a member of Anah Temple of Bangor and the Newport Odd Fellows Lodge. In 1925 he was a captain in the Medical Corps, U. S. Army.

Few physicians in this section of the state have been held in such high regard as was Doctor Emerson and his death is a distinct loss to the community in which he practiced so long and faithfully.

Frans Leijonborg, M. D., 1872-1939

Doctor Frans Leijonborg, 66, Waldo County Medical Examiner, died at his home in Liberty, Maine, on March 30, 1939. He had been in failing health for some time following an attack of pneumonia.

Doctor Leijonborg was born in Mariestad, Vastergatland, Sweden, April 12, 1872. He received his A. B. degree at Skara and attended the Karlsberg Military School near Stockholm. He attended the University of Vermont, Dartmouth College and in 1912 received his medical degree from the College of Physicians and Surgeons in Boston. He was a member of the Knox County Medical Society.

Samuel J. Redman, M. D., 1868-1939

Doctor Samuel J. Redman died at his home in Dexter, Maine, on September 28, 1939, following an illness of several weeks. He was born in 1868, in Hermon, Maine, the son of George and Mary Redman.

Doctor Redman first taught school in Hampden, later serving as superintendent of schools in that town and also in Exeter. He graduated from Bowdoin Medical School in the class of 1899, and practiced sixteen years in Exeter before living in Dexter where he has practiced the past twenty-four years.

Surviving are his wife, Mrs. Bertha Redman; two daughters, Mrs. W. A. Small of Dexter and Mrs. Reginald Taylor of Guilford; two sons, George Redman of Dexter and Floyd Redman of Bryant Pond.

Doctor Redman was known as a skilled surgeon and able practitioner and as such was held in high esteem in his profession and by a large circle of friends.

Winfield Benjamin Trickey, M. D., 1881-1939

Doctor Winfield Benjamin Trickey of Pittsfield died at his home there on August 17, 1939.

He was born in East Corinth in 1881 and later attended the schools of that town. He was a graduate of Bowdoin Medical School, class of 1913, and following graduation served as an interne at the Eastern Maine General Hospital at Bangor.

Sympathy is extended to his wife, the former Florence Buck of Portland, and his daughter, Miss Ruth Trickey.

Doctor Trickey was a practicing physician in Pittsfield for twenty-three years, and during that time made many friends who will feel the loss of a loyal friend and physician.

Book Reviews

"Textbook of Obstetrics—With Special Reference to Nursing Care"

By Charles B. Reed, M. D., F. A. C. S. Assistant Professor of Obstetrics, Northwestern University Medical School; Head of Obstetrical Department, Wesley Memorial Hospital, Chicago; and Bess I. Cooley, R. N., Supervisor and Instructor, Department of Obstetrics, Wesley Memorial Hospital, Chicago.

Published by The C. V. Mosby Co., St. Louis, 1939. Price, $3.00.

This is an excellent textbook. It is based on a full understanding of the seriousness of childbirth in civilized communities, as well as the seriousness of the services to be rendered by the nurse serving the child-bearing woman. Almost every phase in the life of a woman about to give birth to a child, as well as of the newborn baby, is most instructively described and well illustrated in its normal as well as its abnormal aspects. The plan is very well thought out and excellently presented for theory as well as for practice. The book is printed on "eye-toned" paper. It should become a favorite with many nurses, as well as doctors who employ them.

"The Rectum and Colon"

By E. Parker Hayden, A. B., M. D., F. A. C. S., Assistant in Surgery in the Harvard Medical School, Boston, Massachusetts; Assistant Surgeon and Chief of Rectal Clinic, Massachusetts General Hospital, Boston, Massachusetts. Illustrated with 169 Engravings. Published by Lea & Febiger, Philadelphia, 1939. Price, $5.50.

This book represents the accumulated experience of the author during the function of the clinic for diseases of the rectum and colon which was established at the Massachusetts General Hospital in 1928. The work presented is largely surgical in nature and is planned to assist the undergraduate and postgraduate medical student in the diagnosis, treatment and after care of rectal and colonic diseases. In addition to instruction in diagnosis of, anæsthesia and treatment for hemorrhoids, there are also important sections on diverticulitis, multiple polyposis, ulcerative colitis and non-malignant and malignant tumors. There is also a chapter on injuries to and foreign bodies in the rectum. The book should prove of considerable value to the medical student as well as the general practitioner.

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*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

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"The Art of Anaesthesia"

By Paluel J. Flagg, M. D. Visiting Anæsthetist to Manhattan Eye and Ear Hospital; Consulting Anæsthetist to St. Vincent's Hospital, New York; Consulting Anæsthetist to the Woman's Hospital, Sea View Hospital, Jamaica Hospital, Mount Vernon Hospital, Flushing Hospital, Mary Immaculate Hospital, St. Mary's Hospital, Far Rockaway, N. Y., Nassau Hospital, L. I.; Director of Pneumatology, World's Fair, New York City, and Chairman of the Committee on Asphyxia of The American Medical Association. Sixth Edition Revised. 161 Illustrations. Published by J. B. Lippencott Company, Philadelphia, Pa. 1939. Price, $6.00.

The present edition is the culmination of the author's twenty-five years of experience in the practice of the Art of Anæsthesia. It is written for the medical student, intern and general practitioner. Anæsthesia is considered a highly important branch in medicine and should be administered preferably by the physician because he alone possesses the necessary knowledge, by education and training, to properly examine the patient and select the type of anæsthesia most adequate to meet the patient's pathologic state and the surgeon's requirements.

Several of the new preparations are included in the present text and the newer techniques of administration are presented. There is a new classification, suggested by the author, of the various degrees of asphyxiation and remedial measures are described, not only for the purpose of coping with emergencies due to anæsthesia and birth but it also considers the emergencies of industrial and other asphyxiations, due to gases, poisonous vapor, drowning, etc., as strictly belonging within the action radius of the present-day anæsthetist. In order to harmonize the extension of duties with a descriptive professional title he recommends the discontinuance of the term anæsthetist and in its stead employs the term pneumatologist, thereby increasing the practitioner's employability in the administration of gases such as ether, nitrous oxide, chloroform, helium, oxygen, etc., to control pain and save lives as well as for the treatment of suitable clinical diseases.

In revisions of books dealing with such an important subject as the art of anæsthesia, it would be very beneficial to the reader if important revisory information were included at the most appropriate places instead of added as foot notes. Dating of such information as well as of important material in the text designated as "recent" information, or "a short time ago" would add considerably to up-to-dateness of the value of such information, as is here done in the case of Dr. Crile's letter to show that an opinion expressed in 1914 may be and here is acceptable in 1939. The author has again tried to present all the information available in 1939 to make it possible for the anæsthetist to produce good anæsthesia, good for the patient and good for the surgeon; namely, "A rapid and pleasant loss of consciousness, a short period of excitement, a relaxation, which comes on quickly and which is well under way before the operation is commenced, a stage of maintenance under the complete and ready control of the anæsthetist and a knowledge on the part of the anæsthetist, of the exact depth of the anæsthesia at any given time."

"Eye, Ear, Nose and Throat Manual for Nurses"

By Roy H. Parkinson, M. D., F. A. C. S., Head Oculist and Aurist to St. Joseph's Hospital, San Francisco, California. Fourth Edition. 79 Illustrations. Published by The C. V. Mosby Company, St. Louis, 1939. Price, $2.25.

The first edition of this valuable book appeared in 1925. Time and experience seem to have convinced the author that the text and its arrangement are valuable and satisfactory to the nurse.

The book is divided into three parts. Part I contains information on anatomy, physiology, pathology and therapeutic measures on the throat, nose, ear and eye. In Part II are listed the various eye, ear, nose and throat operations; the section is very well illustrated with layouts of surgical instruments as they are required for each type of operative procedure. Part III deals with the public health aspect as related to the care of the eye, ear, nose and throat. In this section a great deal of conservative advice is given concerning the present day attitude in the care of the tonsils and adenoids. The author advises operation only when the family physician feels reasonably certain that the patient will benefit by it. Similarly he demands that a more serious common sense attitude be taken in dealing with the everyday care of the eyes, the ears and the nose.

For Sale

Retiring from practice, I wish to dispose of my office fixtures and surgical appliances, including a fairly large supply of instruments (including eye, ear, nose and throat, gynæcological, male urethral, bone instruments, operating chair, roll-top desk, chairs, instrument trays, sterilizer and books). A fine chance for one practicing at a distance from surgical centers.

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*Speech and Voice Defects: Various Syndromes**

By James Sonnett Greene, M. D.,
Medical Director, National Hospital for Speech Disorders, New York City

The fact that there is a variability among human individuals as regards both physical and mental endowment is, I believe, indisputable. Each individual enters life with certain inborn capabilities and limitations. His subsequent development is affected not only by these innate capacities and physical limitations, but also by the various environmental and educational influences to which he is subjected—these being different in each instance.

Thus people do not develop synchronously according to a schedule, but unevenly and in differing degrees. That is why we rarely find that perfect synchronization of the mental, emotional and physical phases which is present, theoretically, in the so-called normal individual.

In other words, biological and environmental differences are instrumental in hindering the various phases of the organism from developing equally. This uneven development limits the individual's adjustive abilities and thus may create a fertile field for the growth of the dynamic psychogenic factors which underlie irregularities in the personality.

It is of the utmost importance when considering pathologic conditions of voice and speech to realize that they are indicative of variation within the organism.

This variation may be, for example, a gross organic deformity, such as a cleft of the palate, or it may be a fine organic deficiency apparent only in its effects. Since human relationships depend so much on speech, any individual variability which disturbs that function must necessarily be given special attention.

Speech production is a psychosomatic activity—one which involves intellectual, emotional and motor processes—and a disorder in that function, regardless of its origin, must always be considered as involving the personality as a whole.

Before taking up the various types of speech and voice disorders, it may be well to orient ourselves—to get a general idea of the field as a whole. Perhaps the simplest way is to show you the diverse groupings of our

* Read before the eighty-seventh annual session of the Maine Medical Association at Poland Spring on June 26, 1939.

clinical material. The following analytic table illustrates the various types of speech and voice cases treated at our clinic last year (1938):

Registration and Analysis of 2,909 Patients in 1938

	Children	Adults
DYSPHEMIA:		
Stuttering	492	1,190
DYSLALIA:		
Delayed Speech	75	....
Hearing Mutism	12	....
Deaf (Total)	2	2
Deaf (Partial)	9	17
Oral Inaccuracies	194	61
Lisping	35	54
Agitophasia	5	8
Idioglossia	51	....
Dialectal Speech	....	11
Rhinolalia (Cleft Palate, etc.)	31	19
DYSPHONIA:		
Aphonia	....	13
Hypophonia	....	4
Rhinophonia	15	17
Psychophonasthenia	1	37
Trachyphonia	1	6
Paraphonia (Falsetto, Male)	....	16
Other Types	2	25
ASSOCIATIVE DYSPHASIA:		
Spastic Paralysis	5	7
Chorea	1	....
Cerebral Hemorrhage	....	3
Poliomyelitis	....	1
Parkinsonism	....	5
Other Types	....	2
RELATED NERVOUS MALADJUSTMENTS:		
Psychoneurosis	....	4
Other Types	....	4
MENTAL HYGIENE:		
Courses for Parents of Speech Patients	....	472
	931	1,978
Total		2,909

You will note that last year we had about 3,000 cases. The majority of these cases fall under three main groups: Dysphemia (or stuttering); Dyslalia (or articulatory disorders); and Dysphonia (or voice disorders).

Dyslalia

All cases of dyslalia, whether of central or peripheral origin, indicate variation. This variation may be either functional or organic in nature. In gross organic conditions, the physical anomalies are usually quite apparent. For instance, in many of these articulatory disorders, the etiologic factors are often traceable to such conditions as cerebral or hormonal dysfunction, oral or auditory anomalies.

In all cases of dyslalia where physical anomalies of the articulatory organs—such as malformations of the lips, teeth, tongue, hard or soft palate—are the chief or contributing cause of the speech or voice defect, it is most advisable to defer any course of speech or voice training until the organic difficulty has been given medical or surgical attention. However, in almost all cases these preliminary procedures must be supplemented by speech and voice training.

Cleft Palate:

Cleft palate patients, for instance, still demonstrate defective articulation and nasal resonance even after operative procedures have corrected the physical anomaly. This is due chiefly to the fact that the soft palate regulates the exit of air through the nose, and if it is absent, or if, as often happens, the operation shortens it or renders it immobile, the nasal passage remains open and nasality results.

For this reason, the post operative cleft palate patient usually accompanies the sibilant sounds with a peculiar nasal snort. Moreover, due to lack of tonal discrimination (amusia), these patients are often not aware of their own nasality.

Another result of the inelasticity of the soft palate is difficulty in producing the sounds *k* and *g*, which depend upon contact between the soft palate and the back of the tongue. Where the hard palate is affected, the sounds *t*, *d*, *n*, *r*, and *l* are frequently unintelligible; and in cases of harelip, the patient has difficulty in making *p*, *b*, *m*, *f*, *v*, and *w*, because he is often unable to approximate his lips.

In almost every case the speech of the child or adult with a cleft palate can be greatly improved after operation, but this requires a definite speech therapy which must be carried on over a rather long period.

At our clinic, we have found that it is comparatively easy to teach post-operative cleft palate children to form sounds; that is, they soon grasp the idea of position. But they find it extremely difficult to direct the current of air emanating from the larynx. In many

cases, because of the loss of tissue due to the operation, and frequently because of the almost complete absence of the uvula, there is a wide post-nasal space. The vocalized air flows into this post-nasal cavity and the nasal chambers, and nasality results. In other words, instead of directing the current of air through the mouth, the child allows it to escape mainly through the nose.

Aside from the fact that cleft palate repair is a delicate operation, very often the tissue is so scant and friable that results are poor. In other words, there may be only a partial closure of the palate.

In such cases there is a choice between further surgery or fitting the patient with an appliance—an obturator—to obtain occlusion (Fig. 1).

FIG. 1. In many cleft palate cases it is surgically impossible to obtain complete closure, due to scant and friable tissue. In such cases obturators are used. The above illustration shows a dime-shaped opening in the palate and the closure obtained through a special type of obturator.

Because of the cleft palate patient's tendency to allow air to escape through the nose, we have found it necessary, before beginning any actual phonetic drill exercises, to concentrate upon teaching these children to direct the current of air correctly. When a cleft palate patient begins treatment, he is given a special cleft palate kit containing materials which can be readily procured at any five and ten cent store, such as a soap bubble set, rubber balloons, ping pong balls, and light celluloid toys which can be blown across the table.

A clinician who understands children can utilize this simple material to great advantage by devising games that will teach the child breath direction easily and naturally.

We have also developed another special device for the same purpose—an air-flow indicator. The device consists of a transparent plate with a handle attached, an upper frame with a suspended paper flap, and a lower frame containing a pivoted wheel. Each of the frames is provided with a clamp for attachment to the transparent plate.

The indicator is held so that the wheel is

FIG. 2. Teaching the post operative cleft palate case breath direction by means of the Air-Flow Indicator.

on a level with the child's mouth (Fig. 2), and the plate is pressed against the upper lip. In this position, the suspended flap is so placed that any air emitted through the nose immediately causes it to flutter.

The purpose of this device is to teach the child to direct the air current in such a way that he rotates the wheel without causing the flap to move. He can accomplish this by shutting off his nasal passages completely and blowing through his mouth. Once he has learned to shut off his nasal passages in this way and to direct the current of air correctly, phonetic drill exercises are introduced to teach him the positions of the various parts of the speech mechanism in the production of the different sounds.

Dyslalia due to Defective Hearing:

Correcting the oral inaccuracies of the child with defective hearing is another speech-training problem which calls for special equipment and special techniques. The difficulty in training these children lies in finding the medium which will best enable them to appreciate speech sounds. Once this is accomplished, bad speech habits are readily corrected by training in good articulation.

In recent years, hearing devices have been improved to a marked extent, both as to air and to bone conduction of sound. Many hard-of-hearing children are benefited by these devices, some hearing better by air conduction and some by bone conduction. In all cases, an audiometer diagnosis should be made and the hearing aid tuned to its findings.

Of course, where hearing loss is total or nearly total the sense of sight must be depended on in teaching the child to talk, or in correcting his inaccurate speech.

Other Forms of Dyslalia:

Other forms of dyslalia (or defects of articulation) such as lalling, infantile speech, agitophasia (or cluttering), and lisping, while often accompanied by oral anomalies, are in the main due to environmental conditions. They may usually be traced to language conflicts in the home or to poor speech habits of infancy which have been allowed to become fixed. These bad habits are readily corrected by training in good articulation.

Psychic involvements arising from dyslalia tend to disappear with speech improvement.

Dysphemia

The problem of dyslalia is a much simpler one for the speech clinician than is that of dysphemia (stuttering), which is often referred to as a purely functional disorder—a physical manifestation of an underlying psychoneurosis. Because speech is a social medium and closely related to emotional life, stuttering does have important psychoneurotic aspects, but these are only part of the stuttering syndrome.

Neuroses in general have always been regarded as behavior disorders having no organic basis. The idea that these conditions have a non-physical basis is predicated upon the absence of any evident lesions. Our clinical observations, however, definitely point to the fact that, regardless of the absence of definite lesions, neurotic individuals demonstrating functional speech disorders such as stuttering almost invariably show evidence of inherited neuropathic diathesis. Their abnormal behavior is contingent upon defects, limitations or faulty actions in their biologic mechanism which prevent them from making adequate personality adjustments.

These patients all possess a relatively high potential for the spread of emotional tone and a tendency for dominance of the sympathetic division of the autonomic nervous system which far overreaches that of the normal individual. Anxiety states and phobias of various kinds are common, and neuroticism is usually found to be a familial trait. In their contacts with the external world these people are rather aloof, subjective and egocentric —these manifestations usually being defense mechanisms against basic anxiety and feelings of inadequacy or inferiority.

In fact, certain physical and personality traits are so common to people who develop stuttering speech that I have been led to designate them as a special type—the Stutter Type[1].

Let me clarify this term for you by referring to the work of Professor Ivan Pavlov[2].

Professor Pavlov pointed out that an individual's type of personality depends on his nervous excitation and emotional stability. He divided all nervous systems into three basic groups according to the strength, balance and lability shown in nervous functions. In terms of excitation and inhibition of psychomotor function, these groups may be designated as the weak, the moderate, and the strong.

In the latter group, excitatory processes predominate. People in this classification demonstrate strong nervous excitation, rapid reaction, a great capacity for response to stimuli, and a tendency to excitability. They are the so-called temperamental individuals, and among them are many of the leaders in our social, business and artistic life.

Within this group is a special segment which Pavlov classified as "strong but unbalanced." These people exhibit strong tendencies toward both excitation and inhibition, and a certain number of them are prone to disorganization. Their mental and physical activity is constantly being disturbed or inhibited because of uncontrolled reactions. They show a marked combination of the harmful effects of excessive excitation and interruption, so that under the slightest emotional stress their psychomotor activity is disorganized. In other words, there is an interference with that inner rhythm so necessary for the integrated functioning of the individual. This interference is manifested in psychomotor performance by arrhythmia or hesitancy, which is in fact a form of stuttering. For that reason, I have designated this special group the Stutter Type.

The mentality of the stutter-type individual is qualitatively complete, but he is subject to emotional excitement and consequent confusion and fatigue. His highly excitable organism continually demonstrates the inability to exclude irrelevant stimuli while responding to the stimulus proper. His reactions are out of all proportion to the strength of the stimulus, and situations which in a normal person call for a mild or a purely reflex response, elicit from him a very forceful response.

In general, I have found that aside from the purely reflex responses such as walking, the stutter-type has difficulty in carrying on intellectual and motor activity at the same time. He is far less proficient than the normal person in doing "two things at once." If he attempts it, one or the other will suffer; either his motor activity or his intellectual activity will become disorganized. It is this disorganization, resulting from his exaggerated emotional surge, that causes the stutter-type's chronic hesitation.

This hesitation may or may not manifest itself in stuttering speech. It may be demonstrated in many other ways—in sports, in driving an automobile, in playing musical instruments, etc. In fact, only a certain percentage of stutter-type individuals demonstrate their psychomotor disorganization in their speech. But no matter what form their disorganization assumes, they all show evidence of a neuropathic diathesis.

This neuropathic diathesis of the stutter-type is definitely an hereditary factor. Our own observations and those of many other workers in the field have established the fact that there is a familial predisposition toward nervous and emotional instability in these people. It is still a moot question whether this instability can be assigned to a specific organ weakness or inferiority. However, as Dr. Cobb[3] recently pointed out, only structure is inheritable. In the light of this, he

believes that the hereditary nature of many cases of stuttering must depend on "a structural abnormality in the brain." In England, Kennedy and Williams[4] recently arrived at the conclusion that "we may assume the existence of a cerebral cortex which is hypersensitive to any transient vasomotor disturbance brought about . . . by the effort of speech."

Schilder[5] has speculated on the possibility of both stuttering and tics being due to striate body involvement. And I have long felt that because the stutter-type shows a striking imbalance in his autonomic nervous system, the abnormality may in all likelihood be a hypothalamic involvement.

Since the sympathetic nuclei in the hypothalamus are in direct control of the bodily manifestations of the emotions, an involvement in that organ would account for the extreme lability of the sympathetic division of the stutter-type's autonomic nervous system, and for his relatively high potential for the spread of emotional tone. And to go a step further, since the functioning of the endocrine glands is so closely integrated and synchronized with the functioning of the autonomic nervous system, an imbalance in one system implies an imbalance in the other, so that there is almost certain to be a hormonal dysfunction underlying the disorganization of the stutter-type.

However, as I have already pointed out, even with his neuropathic diathesis and his general psychomotor inefficiency, the stutter-type individual does not necessarily develop stuttering speech. Only an unfavorable childhood environment which accentuates the stutter-type's tendency toward disorganization and places unusual emotional stress upon him can evoke stuttering in its various forms[6].

Children who develop stuttering speech are less adept than others in acquiring language and other motor skills, and show a general lack of coördination in all psychomotor activity. This fact was recently corroborated in a study made by Berry[7], of the developmental history of 500 stuttering children as compared with 500 normal children. She found that the children who stuttered were definitely retarded in acquiring motor skills. They were retarded in learning to walk when compared with the non-stuttering children, and also "showed a serious retardation both in the initiation of speech, and in the development of intelligible speech."

The child is vaguely aware of this general inefficiency, and when he is continually subjected to adverse environmental pressure, he very early acquires a keen sense of inadequacy. This sense of inadequacy, in turn, gives rise to morbid anxiety in which the child anticipates with fear each new environmental situation. As the child grows older, fear and anxiety become more and more severe, and his feelings of inadequacy and inferiority more pronounced. He finds himself unable to compete on equal terms with his companions, and withdraws into himself, developing egocentric traits. Thus his social adjustments are definitely retarded and many of his personality traits remain on an infantile level.

Such a child develops stuttering speech as a deficiency specialization — an outward manifestation of his underlying biologic inefficiency and his basic sense of inadequacy. In this respect it must be remembered that "language is the most highly integrated function of the brain, and as such is the most sensitive indicator of the emotions, and the most vulnerable to disturbance." As the child continues to stutter, in the course of time, his personality becomes so warped that he develops a chronic anxiety neurosis and becomes the passive, fearful, indecisive, hesitating individual whom we know so well as the adult stutterer.

Inadequacy and morbid anxiety seriously hinder such a person's drive toward mastery and achievement. No matter how capable he may be in terms of native endowment or education, he feels incapable and lacks the ability to "carry through." Indecision very often interferes with his activity, because anxiety and sensitivity regarding past failures have reenforced his native inhibitory tendencies and have made him a chronic hesitator.

When the slightest environmental pressure interferes with a project or an activity, his anticipatory anxiety and feelings of inadequacy prevail so that he performs inefficiently

or completely abandons the activity. He then makes use of his stuttering speech; it becomes an excuse for lack of accomplishment. It is his all-purpose alibi to which he attributes all his failures and which covers all his deficiencies.

Stuttering speech may thus be said to have an adjustive value, for it enables the stuttering individual to rationalize his failures, which in reality arise out of his disorganized biologic mechanism and his severe personality maladjustments.

From the foregoing syndrome of stuttering speech, it may readily be seen that all therapeutic measures must be directed toward the reconstruction of the personality as a whole. The stutterer must be re-conditioned both physically and psychically so that his vital personality traits are placed in their proper relationship, and he is able to meet and compete with his fellows on an adult level of reality.

Such a far-reaching therapy can be carried out only under special conditions. That is why, at our Medical-Social Clinic[8], we have found it necessary to devise a special group approach and to attack this problem by means of a composite therapy carried out in a specially created environment. This composite medical, psychologic, psychiatric, re-educational and social therapy is applied with the aim of reorganizing the stutterer so that he gains intellectual dominance, emotional control, and physical coördination.

While the psychic aspect of the stutterer's problem has long been recognized, orthodox individual psychiatric treatment has proved insufficient, because the narcissistic barrier that the stutterer has built up between himself and others makes it impossible, in most cases, for him to coöperate with the therapist. Moreover, a *passive* analysis is of little avail. We may interpret the stutterer's problem, but this does not mean that by so doing we solve it for him. To do this he must have the opportunity to work himself out of his anxiety. This can be accomplished only by means of some form of group therapy.

The group therapy at the National Hospital for Speech Disorders is carried out in a medium which, while approximating as closely as possible the environment of the outer milieu, has been carefully devised to remove the seemingly hostile aspects of the outside world which constitute such mental hazards to the stutterer.

It is well known that in order to function successfully, an individual must feel that he deserves, and must receive, social approval. When the stutterer is part of a group, all of whom have similar difficulties, he more nearly attains this end—he develops a wholesome sense of achievement and security, and loses his sense of frustration. The Medical-Social Clinic's group therapy is based on this principle. At the same time the environment has been so arranged that the stutterer has to face, in the therapist and in the group, the reality which for neurotic reasons he has been trying to avoid.

Through our group activities and "open door" psycho-therapy, the stutterer's mind is diverted from verbalization. Speech takes second place, and his interest is focussed on the development of his total personality. Unbridled emotionalism is replaced by a disciplined control of pathologic fear, and his resistance to adjustive suggestion is overcome by the contagion of group response.

Through a series of preparatory experiences, the stutterer repeatedly and successfully faces the situations toward which he has had anxiety. In this way he gradually loses his fear regarding social situations and in the end he acquires a physical coördination and an emotional stability that enable him to take a non-hesitating stand, facing situations squarely and fearlessly.

Finally, his egocentricity is replaced by objectivity to such a degree that he is able to bridge the gap psychologically between our special environment and that of the outside world. He then leaves us, able to act in a rhythmic, organized and confident manner in all situations, speech included.

Dysphonia

Voice disorders, like speech disorders, are also both organic and psychogenic in origin. The underlying causes of the organic voice disorders are usually quite definite and apparent, and the type of local therapy required is more or less clearly indicated. The voice disturbances in these cases—the most

common of which is hoarseness (trachyphonia)—will usually clear up once the underlying lesion is healed.

However, in some cases, such as those of chronic laryngeal stenosis, the patient's voice and speech often remain severely affected even after local therapeutic measures have been successful. In these cases, the acquisition of adequate voice and speech may be greatly enhanced by the introduction of speech and voice training along with local treatment. The following case illustrates this two-fold therapy:

Marie S., age 11, had an emergency tracheotomy for diphtheria when twenty months old. About a year ago she was brought to the Bronchoscopic Clinic of the Manhattan Eye, Ear and Throat Hospital for decannulation. Laryngoscopy at that time showed a larynx completely closed. She has been under a therapeutic regime consisting of dilation with sounds, and the use of core molds ever since.

An initial recording demonstrated her voice and speech after successful dilation of the larynx but before the introduction of speech training. At this time it was hardly recognizable as a human voice at all. It was a distinctly unpleasant, scraping, quacking, tracheal voice, with a pronounced inspirational stridor. She sounded identically like Donald Duck.

Speech and voice training was instituted in conjunction with the dilatory therapy. During the next three months she attended our Clinic twice weekly, receiving one hour's speech therapy at each visit. At the end of this period a second recording was made. The improvement noted at this time was remarkable. Her voice was adequate, although still not normal. Her speech is now readily understandable, however, and progress thus far convinces us that continued therapy will produce a voice and manner of speech normal in all respects.

Functional Dysphonias:

Like stuttering, the functional dysphonias are also psychogenic in origin and are physical manifestations of the underlying neuroticism of certain atypical people. In these voice disorders, as in stuttering, it is not a matter of treating the local involvement, but a question of treating the whole personality.

All of these disorders—psychophonasthenia, hysterical aphonia, and many cases of falsetto voice—are unconscious neurotic compromises which legitimize the afflicted person's withdrawal from social situations to which he feels incapable of making a satisfactory adjustment. They are all defense mechanisms, but each serves its own special purpose.

Psychophonasthenia:

Psychophonasthenia, for example, is used —unconsciously of course— to camouflage real or fancied selective incapacities. Singers, public speakers such as clergymen and lawyers, or business men who are suddenly called upon to face new responsibilities, will often develop psychophonasthenia as an alibi for anticipated failure.

The symptomology is variable, but the patient usually complains of a tight, constricted throat and uncontrollable choking sensations when speaking. His voice is pinched and grating and "cracks" frequently. However, despite these acute laryngeal manifestations, the condition is simply a projection of the patient's basic anxiety which is physiologized through the vocal tract.

Therapy is often difficult and must extend over a long period, because the condition is usually ingrained psychically and intertwined with environmental conditions which seldom can be changed. Besides a composite therapy directed toward personality reconstruction, a course of special training must be instituted to counteract anomalies brought about through constant misuse of the larynx.

Hysterical Aphonia:

Hysterical Aphonia, or functional loss of voice, is another disorder in which the physical dysfunction is due to neurotic background and psychic influence. It is a neurotic escape from an environmental situation which is distasteful to the individual or which threatens his security or happiness. Despite the sudden loss of voice, laryngeal findings, with certain minor exceptions, are almost invariably negative.

These cases require a therapy which is primarily psychiatric. It must be directed

toward the elimination of the etiologic factor. In other words, the precipitating situation or the patient's outlook on the situation must be changed before the hysterical symptom will be permanently relinquished.

I have found that in general, there are three types of hysterical aphonia patients.

The personality and emotional reactions of the first type are on an infantile level, so that while therapy may bring about an apparent cure as far as the vocal symptoms are concerned, fundamentally the patient's outlook on the situation remains the same, which means that the desire for escape still is present. Such a patient will often relinquish his or her hysterical aphonia only to adopt some other hysterical method of escape.

The second type of patient unconsciously resists therapy. His disorder proves such a valuable asset that it is not relinquished until it suits his purpose. The third type, on the other hand, is the patient with a more mature personality. Once this type of patient fully understands the unconscious motives underlying the disorder, he will readily relinquish the hysterical symptom.

A careful anamnesis usually enables the doctor to classify the patient and thus give a more accurate prognosis. The following case illustrates the third type of patient:

Mrs. B. B., 36 years old, lost her voice just before last Christmas. While talking with some friends she suddenly felt a constriction in her throat, as though it were completely shut off. She found it impossible to talk, and for six months was unable to speak above a faint whisper. She received various types of treatment but did not regain her voice.

Several weeks ago, she was referred to our Clinic for treatment by a member of the medical staff of the Manhattan Eye, Ear, and Throat Hospital. After a careful anamnesis it seemed to us that there was an element of sexual frustration present. The patient was given a brief psychotherapeutic interview and assured that her larynx was normal. After being given an insight into the true nature of her vocal symptom, she relinquished it quite readily and there has since been no recurrence of her aphonia.

I wish to point out, however, that the therapist must be very careful not to place the onus for the loss of voice on the patient, but rather on the environment. Every hysterical aphonia patient is to a greater or lesser degree emotionally immature, and resents any implication that he is a malingerer in the sense of using his vocal symptom, even unconsciously, as a means of escape. At our clinic we have found it better to explain that, due to certain environmental pressures (which are discussed in greater detail with the patient), psychic impulses cause inner conflicts which manifest themselves in dysfunction of the larynx. The reason for the selection of the larynx is obvious, since the voice is the medium for personal contact with the environment.

We have also found it advisable in most cases—again because of the immaturity of the hysterical aphonia patient's personality—to give some form of local therapy in the nature of a placebo. This is merely a "face saving" device: i.e., by implying that his psychic conflicts have caused some alteration in the larynx, but that everything is "now" all right—the larynx is "now" normal. It furnishes the patient with an excuse for the sudden return of his voice.

Falsetto Voice

Another symptom complex is paraphonia, or falsetto voice. The voice of the male afflicted with this condition is high, shrill and piping in tone. A popular stigma is fallaciously attached to the person who has a falsetto, because this type of voice is characteristic of the eunuch or eunuchoid. However, in almost all cases the stigma of doubtful sexuality is entirely undeserved, since falsetto voice is usually a purely functional disorder. In its initial stages the condition can usually be considered as simply a neurotic manifestation of exaggerated sensitivity at the pubescent period.

A sensitive boy with neurotic tendencies is more than ordinarily embarrassed by the systemic changes, voice changes included, which take place at this time. He strives to remain on his childish level and clings to his high pitched, shrill voice. Through constant use of this high voice, he causes a faulty coordination and misdirection of the laryngeal

musculature, and the condition, if uncorrected, continues throughout the individual's entire life.

The composite therapy in cases of falsetto voice must take into consideration the individual's psychic state, his laryngeal condition, and his vocal abnormality. The therapist must have both psychiatric and musical leanings in order to bring about complete reorganization of the individual.

Summary

To sum up: we all realize that the underlying causes of the organic speech and voice disorders are very definite and apparent, and for that reason the type of therapeutic procedure is more or less clearly indicated.

In the functional disorders, the underlying causes, while not objectively evident, are just as positive and just as dependent on biologic inferiority (though of a more general nature) as in the organic disorders. Without an inherent psychosomatic predisposition within the organism, there would be no neuroticism. In these patients, conditioned as they are, neurotic behavior must be considered as the only possible reaction of their particular organisms to certain definite stimuli.

Therefore, the therapeutic objective in these cases must be not only to treat the speech or voice disorder, but to introduce a new life pattern which will enable the individual to realize and make use of all his potentials. In other words, a complete reorientation of the personality, not merely speech or voice reconstruction, must be the aim.

The organism as a whole is involved. The individual must be "made over."

It can be done.

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Primary tuberculous infection of the lungs usually takes place without any obvious disturbance in the health of the child, reports MacPherson, who followed 850 children in the Brompton Hospital who showed a positive tuberculin test. The lesion is often a small one, and resistance to infection is usually sufficiently good to allow it to heal. The process of healing takes more than one year and the focus is always a potential source of dissemination of the disease during this time. It is probable that the rate of healing increases with improved nourishment and increased sunlight.—MacPherson, A. M. C., *British Jour. Tuber.*, April, 1939.

A place in the sun—The moment that we get people to living properly we shall see an enormous reduction in disease. One of the most extraordinary things is that the good Lord gives us sunshine and chlorophyll and other things that science talks about and yet when the sun appears man hides himself, and when it disappears he comes out in the open again. God puts His people in the sun and then society comes along and shoves His people back into dungeons and behind bars and in dark rooms—and that is what we call civilization.—Gaha, F., *British Jour. Tuber.*, July, 1937.

*Libraries and the Hospital**

By Jonathan C. Meakins, M. D.,

Professor of Medicine, McGill University Medical School

I consider it a gracious privilege that I have been invited to speak to you this evening, albeit indirectly as it were, of the life and work of one who was deeply beloved and revered by many in this community. New England,—a delightful sound in my ears,—has given to these United States of America a heritage of mental discipline and vision which is not always appreciated. It is true that the last glimpse of England which the earliest settlers saw was that of Plymouth and the Devon coast. But this was to them a foreign environment of a passing moment. The broad moors of Yorkshire and the fenns of the East coast where the horizon was as limitless as the sea, was theirs—where man in the solitude of wide spaces saw the sun rise in its splendour to usher in a day of new hope and promise. The monasticism of the Cambridge intellectual and the asceticism and bigotry of the Puritan were not without their contradictions. Religious and intellectual liberty in our modern sense they did not seek for themselves, nor accord to others; they abhorred it; they trampled on it, and their own lives they subjected to all the rigid restrictions to which they subjected others. They were narrow but strong! It was but natural that this people to the South in Massachusetts should have desired to dominate the more liberal—and actually earlier—settlements towards the Northeast. The long fight of Maine for its Statehood is known to you all. The fundamental differences of geography, economic interests, and political ideals, made such a separation inevitable. But Maine has also had its differences and disputes with my country to the North and West. The refusal to accept the arbitration of 1831 and what we have always considered the unjust compromise of 1842 left its mark of suspicion of the goodwill both of the United States and of Great Britain. Much water has run under the bridge of human affairs during the past century. The peoples of our two countries have grown closer and closer. Over ten percent of your population are Canadians. These I hope are a leaven to your loaf of culture and ideals. We feel close to you in many ways. The character of our countries, the trees, the flowers, the lakes, the rivers, our snows, our flaming autumns and our hesitant but explosive springs, would seem to mold the people and their outlook to a mutual understanding. I personally feel this especially through my profession. The pursuit of health and happiness is common to us all. Our problems and yours are allied if not identical. Our intercourse in matters medical has been close and it is our hope that it will continue so. Your young men come to us for their professional education and our graduates come to you to fulfill their life's work. The intercourse should not stop there but should be renewed from time to time. The day of graduation is but the beginning of a wider and fuller education which should not cease until the long autumn days of life lead us to place the direction of our profession in younger hands.

In what manner can this education be continued through the years? This is a problem which is exercising the minds of many thoughtful men today. There has for centuries been the custom of periodic visits, for short periods and often at long intervals, to centres of Medical education and practice. These were undertaken with the object of renewing and refreshing one's mind. They were usually called in the vernacular of Medicine "Refresher Courses"! Their duration was at the most a few weeks and as their name implies they consisted of a refurbishing of the old with a minimum of the new. Furthermore, if given at a Medical School it was considered proper that they should be con-

* Read at the Frederic Henry Gerrish Memorial Library Anniversary Clinic, Central Maine General Hospital, Lewiston, Maine, May 19, 1939.

ducted independent of the undergraduate courses. This has never appealed to me as a wise but rather a stupid arrangement. Let us consider for a moment what graduate education should be designed to accomplish. It may, I think, be divided into two general categories.

First are the advances in knowledge of disease. This would include the results of researches in biochemistry, biophysics, pathology, experimental medicine, pharmacology, chemotherapy, bacteriology, etc. These results lead to new understanding of aetiology, prevention and cure. This information is conveyed to the medical world by language which is changing with a rapidity attuned to a tempo which at times almost renders us dizzy. After a period of years if one of us had not kept abreast of these advances in science and their methods of expression, how could we acquire an understanding in a few weeks? Many might contend that this would not be necessary but these could not appreciate that to comprehend the basis and rational application of this new knowledge an almost foreign language would be used. All of us as the years pass must forget past conceptions and replace them by new ideas. It is difficult to do. A comparison might be drawn between a child who without any language inhibitions and an adult who knows but one and has no ear for music, with the undergraduate who has no traditions, superstitions or inhibitions of medical knowledge to overcome and those of us who were brought up under a long past medical regime. We may find it hard—nay, indeed, impossible—to comprehend the current trend with understanding, and without this the practice of Medicine becomes a dreary business. The picture of the practitioner with experience, gleaned from many vicissitudes, is an entrancing one. It was born of times when medical education was hard to come by and was transmitted mostly by example and precept. This probably is the best manner and implies the Socratic method; but, there must be granted the premis of almost encyclopaedic knowledge of up to date information. This requires of the preceptor that he, on his part, shall be able to provide this and of the apprentice or student that he be so equipped as to receive it. This in theory and in practice applies to the older manner of medical education and also to that of today. There is practically no difference except in variety and rapidity of change.

The second category of medical education includes that branch of practice which has to do with the mechanical or technical branches of therapeutics, commonly included in Surgery and its special branches. Practically all specialties have been developed upon the invention and application of some instrument of examination and later therapy. The bivalve speculum, the ophthalmoscope, laryngoscope, otoscope, bronchoscope, cystoscope, oesophagoscope, sigmoidoscope, electrocardiograph, X-ray, and so on. As time passed and the mysteries of these special instruments were revealed, their application became more widespread and a greater demand was expressed for instruction in their use. In this manner instruction in both instrumental and surgical technique came into greater demand. Contrary to the first category, these techniques could in some instances be acquired in a comparatively short time by practice under proper supervision. This was unfortunate as it encouraged certain branches of Medicine to be practised in a superficial manner.

The distinction that I wish to draw between these two general categories of graduate education is that the first rests upon fundamental knowledge which is dynamic, while the second is based upon the acquisition of a manipulative technique which in its essence will shortly become static. Both have their uses, but their relations to the progress of medical knowledge are fundamentally different. The first is best acquired by returning with a humble and open mind to the status of the undergraduate. Work with the fresh young minds which are not yet confused by conclusions which have been found to be wrong but which are hard to forget! Learn with them again a new vocabulary of fresh science! To do this after a lapse of time might be difficult but not necessarily so as there are ways to the same end if we devote ourselves regularly to the task.

Printing opened to the mind of man a new world. It would be an interesting study to compare the development of science and the trade of book building. Did the book stimu-

late the mind to higher accomplishments or did it merely force the growth and accelerate to fruition the seeds of thoughts by acting as a fertilizer! There is little doubt to my mind that men were stimulated to accomplishment by mental intercourse through conversation and by letters. These, however, had a limited radius. The printed book had a wider one, but books were relatively few and expensive, while transportation was difficult.

The history of Medical Libraries is of great interest as history often is a good prophet in general evolution as applied to the future. We are at present interested in the library as it has influenced medical thought and education in this country. It is true that at certain of the older seats of learning, such as Harvard, Yale, Pennsylvania, Columbia, and a few others, Medical Libraries or sections within the general libraries have for many decades afforded excellent facilities for the student and teacher. But these were the exceptions rather than the rule; and, further, how meagre were the library facilities in the hospitals for ready reference by the Staff? Perhaps the latter, as now, did not create a demand and if a library were available they did not take advantage of it. I was greatly impressed by the following which I read some months ago in the proceedings of a Round Table Conference on Hospital Libraries — "The general trend seems to be away from the use of libraries by society members, particularly the younger ones. The students seem not to be educated to read books, so they do not care whether there is a library or not. There is an increasing lack of interest, but societies can foster that interest when public and other libraries cannot." This seems to me to be a particular indictment of our present methods of education or the exposure of a particular gap in our professional philosophy.

Those cells which, when fertilized, eventually grow into centres of culture and intellectual attainment are not primarily composed of great buildings and marble halls but are rather humble structures inhabited by keen minds who turn to books to reveal what other men have thought. There are few great advances in this world which have sprung from one man as a primary concept. It is surprising how many can be traced back through many stages in each of which a small increment has been added from time to time. Books have been the repository of these as decade followed decade. The knowledge is mostly there if we know how to interpret it after we have had the curiosity to seek it out.

The beginnings of many endeavours in medical education reveal this appreciation of the value of books. A few examples may serve to illustrate this.

John Fothergill, a successful practitioner in London, became a close friend of Benjamin Franklin and through him many young men from America were helped to obtain positions in the London hospitals and finally to get their degrees at Edinburgh, Fothergill's Alma Mater. In 1762 he sent from London to the Managers of the Pennsylvania Hospital a book entitled, "An Experimental History of the Materia Medica," by William Lewis, F. R. S., which, Fothergill wrote, was a present to the Hospital "for the benefit of the young students in Physic who may attend under the Direction of the Physicians." In 1763, the Medical Staff informed the Managers that they proposed to devote all the fees to which they were entitled from students attending their courses at the Hospital to the purpose of buying books and establishing a Medical Library in the Hospital. So was started by Fothergill the first hospital library in North America. It was primarily an educational venture which originated for the students but eventually was a source of great intellectual profit to the Staff as well. This was before the first Medical School was founded in this country, namely, the Medical School of the College of Philadelphia in 1765 (as the University of Pennsylvania was then known).

The history of this early library reveals some of the difficulties which we must cope with even today. The library was first put under the charge of the apothecary,—a wise choice as he resided in the institution and was most likely a paid employee. Later, when the Hospital took resident apprentices —the internes of today—they took over the work of the apothecary including the library. This was a good business arrangement as the apprentices were unpaid, indeed were probably charged for their keep if not far more, as was the accepted custom. The inevitable

happened in spite of strict regulations of the Managers. Books were lost! Because, it was claimed, the apprentices were careless — a common but by no means justifiable claim of today! What is the business of many is the accomplishment of none! Eventually, in 1844, a librarian was again appointed who like the apothecary had other duties but at least the responsibility was fixed. The scheme succeeded because William Gunn Malin was a born bibliophile, the moral being that a library cannot be nourished and protected except by a librarian.

Shortly after this, namely in 1780, one of the most remarkable episodes in the history of education in this country began to be enacted. It was in this year that the General Assembly of Virginia endowed the inhabitants of Kentuckee County with certain lands for educational purposes. I shall not enter into the political and religious rivalries of the next twenty years. Out of these was born Transylvania University. Medicine with Law were the first faculties formed. Our interest is in the former and its share in the library. This was founded in 1784 and in 1799, when the Medical Faculty was established, five hundred dollars were appropriated for books. The first bill is still preserved in an itemized form and amounts to seventy-seven pounds and four shillings. Men of a different calibre were apparently in control twenty years later when the Dean, Doctor Caldwell, was sent to Europe with a credit of eleven thousand dollars to purchase new books and publications, and again in 1839, Doctor Peter was sent to Europe with six thousand dollars for books and five thousand for other equipment. These are goodly sums even for today but their relative value of that time was many times greater.

One hears little of Transylvania University today, — and nothing of the Medical Faculty as it ceased to exist in 1858. The Library, however, remains a monument to those pioneers. One might wonder why they spent so much on books. Doctor William Welch answered that query when he said "Transylvania was the best of the Schools," an answer which says much in a few words.

I wish you now to turn with me to the North. In the second decade of the last century four Scottish graduates — three from Edinburgh—banded together in Montreal to provide some instruction—rather informal at first—to the English-speaking young men who desired to prepare themselves for the Practice of Physic. They had no facilities but their own practices. In 1818 the Ladies' Benevolent Society started a small almshouse known as the "House of Recovery" for the care of the indigent sick. These doctors offered their services gratis which were gladly accepted. The "House of Recovery" was enlarged in 1819 and became the Montreal General Hospital which moved to its present site and more commodious quarters in 1822. They now had available a place to instruct their students and to provide them with practical experience of a less circumscribed character. It was natural that these men imbued with the Scottish tradition should aspire to create an organized body for the teaching of Medicine. This they did in 1823 when they founded the Montreal Medical Institute which, in 1829, became the Medical Faculty of McGill University. The Minutes of the first meeting of the Montreal Medical Institute, held on August 10, 1823, record—"It is resolved, first to establish a Medical Library to carry which into execution the members of the Institution have imported some of the periodical medical journals as a commencement." Thus, the first Medical Library and the first Medical School of Canada were born on the same day. One might say they were Siamese twins. This is our Medical Library of today to which Osler was passionately devoted; where now his ashes rest with his beloved books around him.

I have mentioned these three episodes in some detail. They reveal, I think, the importance the library played in medical education and advancement in the early days of North America. Many others could be cited but they are I think representative. The first in the comparatively metropolitan Philadelphia, the second in the "Wilderness" West of the Alleghanies—the land of the Cherokee Indians—and the third by a few men surrounded by an alien race.

The history of the Medical Libraries of North America has not always revealed that appreciation of their value and their importance which one would have expected. Towards the end of the nineteenth century

even the greatest libraries of the day were struggling to remain alive, nursed by a faithful few. The story of the library of the New York Academy, for example, tells a tale of periodic stagnation and expansion, until now it is the third largest Medical Library in the world! while a scant twenty years ago its future looked bleak indeed.

The skeptical may ask why the importance of a library in a hospital? The answer is simple. Books today as never before are the most valuable tools of our trade, science or art, as you please. History records not to the contrary a time when books contained so much important information. I do not claim that all the information is equally valuable—probably seventy percent is valueless or worse; but, the remainder is pure gold indeed.

From my observations I have concluded that my colleagues in Medicine can as a rule be divided into three groups. There are those who read religiously, or at least subscribe to several periodicals as they would their daily newspaper. In addition they buy from time to time new textbooks, all of which they read conscientiously and with profit to themselves and incidentally to their patients. This reading is often difficult to accomplish in a very busy life, but discipline conquers! Many of them have no access to a library therefore their reading is necessarily limited. The second group includes many of the first but in addition they tackle the difficult problems of each day by reference to their books. They are probably not as systematic readers but many times are more effective. To them a library—particularly in a hospital—is a godsend. When a point is in dispute, or an unusual situation in diagnosis, interpretation or treatment occurs, reference to the experience of others as found in the literature is best settled at the time. The association of ideas of the case and the problem both aid memory and understanding. Postponement never leads to finality. But it may be said that the point in reference may not always be unearthed by the means at hand. The pertinent articles may not be discoverable or available at the moment. It is for such circumstances that the services of a librarian are all important and I believe it is the duty of a hospital to provide such as it should the other essentials for proper practice of our profession within the hospital. It is surprising how much help a properly trained woman or man can give in this regard to make the work of the profession both interesting and successful.

Then, finally, there are those who never read or practically never. For these there is little hope! It is in the nature of things that they cannot keep abreast of the times.

Medicine, as I have already stated, is advancing at a rapid pace. To keep up with all branches is impossible, but to aspire to it in some degree is our duty. Acquisitiveness for medical knowledge is truly greatness;—how greater still is the opening of channels to knowledge! Personal knowledge, medical or otherwise, is limited by nature;—limitless, however, is the perpetuation of knowledge. Vision is given to a single mind in accumulation of knowledge;—perpetuation of knowledge to many requires greater and broader vision. Such perception and vision are truly attributes of the Bingham Associates in their numerous missions;—especially great is their vision in making possible the Gerrish Memorial Library as a center and model of medical learning. Appropriately does this library bear the honorable name of Frederic Henry Gerrish. He was a man who knew books, loved books, and was well known as an editor. It is interesting to speculate to what extent Doctor Gerrish may have been influenced by Timothy Little. His love of anatomy would seem but natural considering his Little Heritage. Also I think his meticulous accuracy could be so ascribed although others have accorded this to his watch-making father. An anatomist and a watch-maker must be equally exact and have other similarities. The teacher must be the perpetual student, and the student the constant teacher of himself if not of others. The last word will never be written nor spoken and he who feels himself complete in knowledge has indeed ceased to learn. It is the hope of many that this library and eventually thousands like it in the hospitals of this land shall continue as centres of perpetual education. The new in thought and deed shall always be found here so that he who seeks may learn.

*Urinary Complications and Water Balance**

By C. Harold Jameson, M. D., Rockland, Maine

Acute retention of urine

Its occurrence is not common in my experience after general surgical procedures except in those involving the lower abdomen, vaginal plastics and rectal cases. Incidence is no doubt higher in nervous individuals.

Prevention

Pre-operative catheterization is advisable in gynecologic cases and in lower abdominal procedures, vaginal plastics and rectal cases. Overdistension is thus guarded against as well as mechanical interference by the partially distended organ at operation. Pre-operative catheterization at the table insures an empty bladder for indicated procedure, minimizing trauma to that organ which not uncommonly distends with urine rapidly secreted by nervous individuals after the bladder has been emptied on the ward.

In selected cases the employment of an indwelling urethral catheter placed before or following the surgical procedure is useful; for example cases of extensive intestinal resection, hemorrhoidectomy or other procedures requiring dilatation of the anal sphincter.

Acute retention is not to be confused with delayed or reduced secretion dependent upon insufficient fluid intake and negative water balance. The post-operative patient who has not voided after 18 hours may require administration of additional parenteral fluids rather than passage of a catheter into a not yet overloaded bladder.

Atonic Bladders and Spasmodic Sphincter

Elderly, weakened or severely shocked patients either following surgery or accidental trauma occasionally exhibit atony of bladder musculature as well as the more obvious weakening of skeletal muscle. Relief of retention must be accomplished by catheterization. However, particular warning is sounded in case of certain elderly male patients against precipitate haste to read into the picture obstructing prostatic disease. Many of these cases will resume urinary function if conservative treatment of the immediate problem be exercised.

Catheters and Technic

For intermittent catheterization of the female, the glass catheter is preferable, both for ease of manipulation and for insurance of asepsis. The retention catheters preferred are the soft rubber 4-wing catheter or the Pezzer catheter.

For catheterization of the male patient, the soft rubber Wishard catheter is used reinforced when indicated by the stilette. This catheter functions satisfactorily for constant bladder drainage.

Following catheterization for any reason lavage should be practiced with sterile boric solution or distilled water.

I doubt if there be danger in completely emptying distended bladders save in cases of renal insufficiency.

Urinary Suppression

Inadequate urinary output post-operatively may be erroneously ascribed to primary renal disease. Where such a diagnosis is untenable on the bases of adequate pre-operative case study, one should think first of all of fluid imbalance. Oliguria, albuminuria, even red blood cells in the urinary sediment may mean dehydration rather than primary kidney insufficiency. Much emphasis on this point is requisite to successful post-operative management. *Chronic retention* of urine post-operatively is more commonly overlooked. When observed it is probably more surely a condition involved in a long-standing morbid state, associated or not with the immediate surgical problem. Its evaluation falls outside the scope of the present discussion.

In the realm of obstetrics, however, the

* From the Round Table discussion of Post-Operative Complications presented at the 87th Annual Session of the Maine Medical Association, Poland Spring, Maine, June 26, 1939.

problem is of more pertinent interest. Post-delivery retention is probably common. After several required catheterizations the convalescent voids in fair amounts yet a catheter will discover residual urine in the still atonic bladder. Appropriate measures to check this condition before such patients are discharged from observation are urged. Otherwise chronic retention at first unnoticed will progress with chronic cystitis, possibly chronic pyelitis and pyelonephyritis. Even calculus formation may ensue. A parallel condition following acute retention in post-operative cases does occur with prolonged morbidity and with identical sequelae.

Post-operative *incontinence* of urine has been infrequent in my observation. If present, injury to bladder or urethra or vesical sphincter must be considered and searched for. Incontinence of distension may be present but should be obvious. In aged or debilitated patients incontinence from relaxed sphincters may present a problem complicating adequate nursing care whereupon a well chosen indwelling catheter will simplify the equation and contribute largely to the patient's comfort.

Other instances of post-operative urinary complications will occur to you, no doubt, and provide questions of general interest. Those already referred to would appear to include situations commonly encountered.

Water Balance

Summary of various fluid requirements for water balance may be made. The daily normal fluid intake will vary from 800-2000 cc. The fluid proportion of solids taken is 1000-1500 grams of water. Normal water losses occur through the usual sources as follows: by lungs and skin for equalization of body temperature, 1000-1500 cc: of this 25% is lost by vaporization (variable) and 75% by radiation, conduction and convexion; by kidneys at least 500 cc daily to excrete waste products, and this volume may be much increased if the kidney lacks concentration power or if excessive waste is available for elimination. Coller[1] states that the vaporization process has "preferential rights" over the kidney usurping fluids readily for its own variable needs.

The sick surgical patient requires on the average, fluids (1) to make possible elimination of waste by the kidney (1500 cc) and (2) to provide for the vaporization process (2000 cc)[2].

In addition to these fairly fixed amounts, fluids must be supplied to offset abnormal losses resulting from excessive perspiration in the operating room and in the post-operative period, blood losses (averaging 300 cc. in 18 cases studied) at operation; in the post-operative period, fluid losses from vomiting, diarrhea, wound exudates, fistulous discharges, excessive sputum et alia. These evident abnormal losses are measurable and must be recorded by nurse to provide the additional increment to be supplied.

1. Water for kidney needs, 1500 cc.
2. Water for vaporization, 2000 cc.
3. Water to compensate abnormal loss, —— (variable)

3500 cc. plus

So much for replacement fluid requirements for the average surgical patient.

Separate consideration is merited for the well-recognized concept of dehydration, aptly named "medical shock" by *Callis*. Dehydration may be overlooked if abnormal fluid losses by the patient be disregarded. The clinical features of dehydration are easily recognizable—dry skin, sunken eyes, red-dry tongue, restlessness, low-grade fever, elevation of non-protein nitrogen, presence of low volume of urine excreted with trace of albumin, even a few erythrocytes; and in infants or children the same physical signs plus evidence of loss of subcutaneous fluids in the paniculus of the abdominal wall, on the medial aspects of the thighs, lusterless eyes, sunken fontanelle, and not infrequently convulsions.

Coller[2] states that to produce dehydration in the healthy individual water in proportion 6% of body weight must be withheld.

Body Weight	6%
22 lbs.	600 cc.
44 lbs.	1200 cc.
132 lbs.	3600 cc.
176 lbs.	4800 cc.

For correction of dehydration it is evident then that the amount of fluids required for routine physiological purposes (3500 cc.) must be largely augmented by 6%, dependent upon the patient's weight and degree of medical shock. In its incipient stages dehydration progresses with insensible water losses. At first there is no profound disturbance of the important cellular chemistry in keeping with the broad factor of safety an extravagant nature provides. Callis[3] writes: "Dehydration may occur to the point where the body loses 1.5% of its weight by water loss before there is a disturbance of the sodium-potassium equilibrium. Up to this point apparently any drawn upon blood plasma is compensated for by replacement of water in blood from water in the intercellular fluid. (Free water). The change is one of water position and not one of water chemistry since the sodium ion alone is involved." Beyond this point as dehydration proceeds fixed water is given up from its intra-cellular position taking with it potassium. The plasma sodium then combines with water freeing potassium which, excreted as phosphate in the urine, represents a definite criterion of cellular damage.

The failure promptly to recognize the state of dehydration in a patient whose abnormal fluids losses have been overlooked has been stated. Coller warns: "The resulting poor output of urine is often erroneously attributed to a reflex or toxic suppression of kidney function, whereas the real fact is that the patient has not been given sufficient water. This point cannot be too strongly emphasized."

A simple chart for recording the state of fluid balance or imbalance is suggested by Charnock[4].

NAME·..... AGE:... WT.. DATE	WATER BALANCE CHART.				
WATER DRUNK					
WT. FOOD. GMS					
PARENT. FLUID					
INTAKE·TUBE					
TOTAL INTAKE					
WATER BAL					
TOTAL OUTPUT					
OUT·PUT TUBE					
STOOL(200)					
SP. GR U ED.					
ABNORMAL LOSS					
URINE OUT					
INS. WATER					
SKIN·D 1000 MOIST 2500					
WET 2000 DRIP 2500					
BOUT T R					

(CHARNACK) 4

Fundamental considerations of water balance have been briefly presented in the foregoing. Principles and methods of correcting imbalance will shortly be discussed.

The state of positive water imbalance in association with hypo-proteinemia occurs in other conditions than the pregnancy toxemias. Interesting animal experiments are reported by Kerkhof[5] demonstrating the development of water retention as a result of diminishing the plasma osmotic pressure by plasmaphoresis. Restoration of plasma osmotic pressure by intravenous injection of inert protein (6% acacia solution) promoted a change in balance and excretion of water and salt.

In the field of obstetrics as well as in neurology and neuro-surgery factors of water imbalance must be considered. The traumatic cerebral states and certain cerebral toxic states, while characterized by local wetness and edema, are not primarily fluid imbalance and will not be reviewed. It is well appreciated, however, that in these conditions dehydration therapy becomes of utmost importance.

Therapy for water imbalance

Rational treatment of patients needing fluids presumes an appreciation of several factors;—why does he require fluids? is he dehydrated? does he need energy? has he lost salt? has he bled? does he require dehydration? has he a normal or abnormal cardio-vascular system, or impaired renal function? has he visible edema? what is the volume of the urinary excretion?

From the foregoing consideration the significance of these questions becomes clear. Fluids must be supplied, not indiscriminately but with proper regard for amount, purpose, route, length of time administered and results obtained. Coller states: "From clinical observation it his been our impression that while many conditions predisposed to retention of fluids in sick surgical patients the precipitating factor was frequently the indiscriminate use of saline solutions." It has been observed by Coller and others that many patients coming to autopsy show tissues to be waterlogged! Water intoxication does occur even with fatal termination. One case resulted from complete and fatal imbalance following proctoclysis alone (Helwig)[6]. Very general use of salt solutions have resulted in many instances of post-operative edema. Jones and Eaton[7] observed 21 patients manifesting post-operative edema in a group composed in the main of gastro-intestinal cases; here imbalance was ascribed to hypo-proteinemia (malnutrition and massive hemorrhage) as well as excessive salt.

Solutions Employed

Normal saline (0.9 grms. salt). Employed to supply water for kidney needs and losses by vaporization. If long continued or in presence of reduced osmotic pressure in blood (Proteinemia) can and does promote tissue retention of fluid; should be supplemented by 5% glucose or Ringer's solution.

Hypertonic Saline (4 grms. salt). May be employed when salt loss known to have been excessive, persistent vomiting, intestinal obstruction, pneumonia. Do not over supply and remember that salt loss per liter of vomitus is essentially that supplied in liter of normal saline.

Ringer's Solution (8.5 grms. Na Cl-0.3 gms. KCL-0.2 gms. Ca per L) is preferred by Horsley and recommended by Coller above normal saline. The potassium and chlorid ions are beneficial to heart beat and are present in the same proportion as in blood. The percentage of salt is practically the same as in normal saline.

5% Glucose (in distilled water is isotonic with blood) supplies energy requirements, supplies water, removes danger of promoting water retention and effects reduction of edema.

10% Glucose (hypertonic) causes dehydration rather than hydration.

Acacia. If blood volume is reduced acacia is second only to blood transfusion in raising blood volume and B. P. Use 6% solution in normal saline or 5% glucose in amounts of 500-1000 cc. According to Bechtold: "The solution should have an amber color and must never be used if it is turbid or dark brown." This solution will also raise the osmotic pressure of plasma, so promoting dehydration. (Note above).

Treatment of Dehydration:

When degree unknown, Coller advises determination of the blood chlorids on alternate days—and estimation of carbon-dioxide combining power. If low he uses 1500-2000 cc. of Ringer's Solution each day alternating with dextrose solution during the corrective period. If the case is under hospital observation from onset use Ringer's Solution in amount *equal to amount* of *vomitus* thus re-supplying electrolytes and not overloading with salt. Provide for normal water needs by use of 5% dextrose.

An observation by Charnock[4] is pertinent to the effect that an increasing NPN which approaches normal as adequate fluids are supplied indicates a state of dehydration rather than renal insufficiency with urine retention. He also subscribes to the very important opinion that post-operative edema may be caused by excessive salt solution, not by glucose; and that such edema indicates a drop in plasma protein with accumulation of sodium ion. With discontinuance of salt solution and substitution of 5% glucose, water is supplied yet the edema subsides as glucose is oxidized and excess salt in tissue taken up by water and excreted.

General Considerations

In conclusion, several observations are worthwhile in respect to methods of supplying parenteral fluid.

Proctoclysis affords slow absorption where the portal circulation is impaired; frequently contra-indicated for one or another reason in sick patients. *Hypodermoclysis* is painful; if used add 10-15 cc. 1% novocain to 1000 cc. Sub-pectoral route preferable pointing needle at mid-point of clavicle; in infants or young children select point between scapular. *Intravenous* route is preferable being without pain. Abundant fluids may be given. Indwelling canula unnecessary as a rule and greater danger from phlebitis thus invited. May use 500 cc. per hour. Unnecessary at that rate to provide warming apparatus as room temperature usually adequate. Danger from injected air to vein negligible—forced injection causing only danger.

Prepared solutions are in general acceptance as safe and satisfactory. Even in cardiac cases it is generally felt that no danger will result from use of intra-venous fluid at rate of 500 cc. per hour.

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Rubbing the Eyes as a Factor in Causing Common Colds

In the December issue for 1938 of the Journal of the Connecticut State Medical Society is a letter from Dr. W. C. Deming of Litchfield relative to the common cold being caused by rubbing the eyes with the fingers, the substance of whose letter can well be employed as advice worth while. It is certain that some diseases are communicable through the eye, for anything that enters the conjunctival sac, and can pass through the nasal duct, reaches the interior of the nose within a few seconds. If this is possible, that is infection, in the cases of certain diseases why not the common cold?

Dr. Deming, it would seem, makes a timely and pertinent suggestion. The habit of rubbing the eyes with the fingers many times a day, if we would even check on ourselves in this, is almost automatic hence hard to break. Warnings of this kind seldom reach the laity and, curiously enough, it would seem that the profession has given little or no thought to it; probably too simple. Putting contaminated fingers into the nose or mouth, rubbing the eyes with them, at a season when the pestiferous cold is a common affliction, carries a danger easy to avoid and one that should be impressed upon patients and ourselves. Since Dr. Deming says: "Personal experience, once the habit of rubbing the eyes with the bare fingers was broken, has been unprecedently long periods of freedom from colds" we surely can and should take this simple and worthwhile advice for its common-sense value.

The Platform of the American Medical Association

1. The establishment of an agency of federal government under which shall be coördinated and administered all medical and health functions of the federal government exclusive of those of the Army and Navy.

Today the medical and health functions of the United States are divided among a multiplicity of departments, bureaus, and federal agencies. Thus, the United States Public Health Service is in the Federal Security department; the Maternal and Child Welfare Bureaus in the Department of Labor; the Food and Drugs administration in the Department of Agriculture; the Veterans' Administration and many other medical functions are separate bureaus of the government. The WPA, CCC, and PWA are concerned with a similarity of efforts in the field of preventive medicine. The Federal Works Administration and the Federal Housing Administration also have some medical functions.

Since 1875, the American Medical Association has urged the establishment of a single agency in the federal government under which all such functions could be correlated in the interest of efficiency, the avoidance of duplication, and a saving of vast sums of money. Such a federal health agency, with a secretary in the cabinet, or a commission of five or seven members, including competent physicians, would be able to administer the medical and health affairs of the government with far more efficiency than is now done.

2. The allotment of such funds as the Congress may make available to any state in actual need for the prevention of disease, the promotion of health and the care of the sick on proof of such need.

The physicians of the United States have given freely of their time and of their funds for the care of the sick. Their contributions to free medical service amount to at least $1,000,000 a day. The physicians of this country have urged that every person needing medical care be provided with such care. They have urged also the allotment of funds for campaigns against maternal mortality, against venereal disease, and for the investigation and control of cancer. The medical profession does not oppose appropriations by Congress of funds for medical purposes. It feels, however, that in many instances states have sought aid and appropriations for such functions, without any actual need on the part of the state, in order to secure such federal funds as might be available. It has also been impossible, under present technics, to meet actual needs which might exist in certain states with low per capita incomes, with needs far beyond those of wealthier states, in which vast sums are spent.

It is proposed here simply that Congress make available such funds as can be made available for health purposes; that these funds be administered by the federal health agency, mentioned in the first plank of this platform, and that the funds be allotted on proof of actual need to the federal health agency, when that need be for the prevention of disease, for the promotion of health, or for the care of the sick.

3. The principle that the care of the public health and the provision of medical service to the sick is primarily a local responsibility.

Obviously if federal funds are made available to the individual states for the purposes mentioned in the second plank of this platform, there might well be a lessened tendency in many communities to devote the community's funds for the purpose, and, in effect, to demand that the federal government take over the problem of the care of the sick. Hence, it is suggested that communities do their utmost to meet such needs with funds locally available before bringing their need to the federal health agency, and that the federal health agency determine whether or not the community has done its utmost to meet such need before allotting federal funds for the purpose.

4. The development of a mechanism for meeting the needs of expansion of preventive medical services with local determination of needs and local control of administration.

The medical profession is not static. It wishes to extend preventive medical service to all of the people within the funds available for such a purpose. Obviously, this will require not only a federal health agency which may make suggestions and initiate plans, but also a mechanism in each community for the actual expansion of preventive medical service and for the proper expenditure of funds developed both locally and federally. In the development of new legislation such mechanism may be suitably outlined.

5. The extension of medical care for the indigent and the medically indigent with local determination of needs and local control of administration.

The medical profession does not yield to any other group in this country in its desire to extend medical care to all of those unable to provide themselves with medical service. The American Medical Association through its House of Delegates has already recognized the possible existence of a small group of persons able to provide themselves with the necessities of life commonly recognized as standard in their own communities, but not capable of meeting a medical emergency. It is recognized, however, that only persons of the same community fully familiar with the circumstances can determine the number of people who come properly under such classification and that only persons in actual contact with such instances are capable of administering suitably and efficiently the medical care that may be required. Hence it is the platform of the American Medical Association that medical care be provided for the indigent and the medically indigent in every community but that local funds to be first utilized and that local agencies determine the nature of the need and control the expenditure of such funds as may be developed either in the community or by the federal government.

6. In the extension of medical services to all the people, the utmost utilization of qualified medical and hospital facilities already established.

In the so-called National Health Program it is asserted that one-half the counties of the United States are without suitable hospitals, and vast sums are requested for the building of new hospitals. In contrast, reputable agencies within the medical profession assert that there are only 13 counties more than 30 miles removed from a suitable hospital and that in 8 of those 13 counties there are five people per square mile. In the United States today the percentage of hospital beds per 1,000 of population is higher than that of any other country in the world. This fact is completely ignored by those who would indulge in a program for the building of great numbers of new hospitals.

Moreover, it seems to be taken for granted that hospital building has languished in recent years, whereas considerable numbers of hospitals have been built with federal funds by various state agencies and also by the PWA, the WPA and by the Federal Works Administration.

Analyses may indicate that in many instances such hospitals were built without adequate study as to the need which existed or as to the possible efficient functioning once it was erected. Moreover, there is evidence that in recent years many of the hospitals of the United States known as nonprofit voluntary hospitals have had a considerable lack of occupancy due no doubt to the financial situation in considerable part. It seems logical to suggest then that such federal funds as may be available be utilized in providing the needy sick with hospitalization in these well established existing institutions before any attempt is made to indulge in a vast building program with new hospitals. In this point of view the American College of Surgeons, the American Hospital Association, the Catholic Hospital Association, the Protestant Hospital Association and practically every other interested voluntary body agree.

Again it has been argued that the demands for medical care in some sections of the country might require the importation of consider-

able numbers of physicians or the transportation of numbers of physicians in the areas in which they now are to other areas. In this connection it would seem to be obvious that a change in the economic status of the communities concerned would result promptly in the presence of physicians who might be seeking locations. The utilization of existing qualified facilities would be far more economical than any attempt to develop new facilities.

7. The continued development of the private practice of medicine, subject to such changes as may be necessary to maintain the quality of medical services and to increase their availability.

In the United States today our sickness and death rates are lower than those of any great country in the world. This fact was recognized by the President of the United States when he sent the National Health Program to the Congress for careful study. The President emphasized that a low death rate may not mean much to a man who happens to be dying at the time of tuberculosis. The medical profession recognizes the importance of doing everything possible to prevent every unnecessary death. At the same time it has not been established by any available evidence that a change in the system of medical practice which would substitute salaried government doctors for the private practitioner or which would make the private practitioner subject to the control of public officials would in any way lower sickness and death rates.

There exists, of course, the fact that some persons are unable to obtain medical service in the circumstances in which they live and that others, surrounded by good facilities, do not have the funds available to secure such services. Obviously here again, there is the question of economics as the basis of the difficulty and perhaps lack of organization in distribution of medical service and a failure to utilize new methods for the distribution of costs which might improve the situation.

The medical profession has approved prepayment plans to cover the costs of hospitalization and also prepayment plans on a cash-indemnity basis for meeting the costs of medical care. It continues, however, to feel that the development of the private practice of medicine which has taken place in this country has led to higher standards of medical practice and of medical service than are elsewhere available and that the maintenance of the quality of the service is fundamental in any health program.

8. Expansion of public health and medical services consistent with the American system of democracy.

Careful study of the history of the development of medical care in various nations of the world leads to the inevitable conclusion that the introduction of methods such as compulsory sickness insurance, state medicine and similar technics results in a trend toward communism or totalitarianism and away from democracy as the established form of government. The intensification of dependence of the individual on the state for the provision of the necessities of life tends to make the individual more and more the creature of the state rather than to make the state the servant of the citizen. Great leaders of American thought have repeatedly emphasized the fact that liberty is too great a price to pay for security. George Washington said, "He who seeks security through surrender of liberty loses both." Benjamin Franklin said, "They that can give up essential liberty to obtain a little temporary safety deserve neither liberty nor safety."

In these times when the maintenance of the American democracy seems to be the most important objective for all the people of this country, the people may well consider whether some of the plans and programs that have been offered for changing the nature of medical service are not in effect the first step toward an abandonment of the self-reliance, free will and personal responsibility that must be the basis of a democratic system of government.

The absolute diagnosis of lymphoma can be made only by biopsy. Whenever the disease is suspected, every effort should be made to find a lymph node or other lesion which can be removed and studied microscopically.—J. H. Means, M. D., *Jour. A. M. A.*, August 19, 1939.

The President's Page

To the Members of the Maine Medical Association

For several years the attendance at the Fall Clinical meetings has been rather disappointing.

Excellent programs have been planned and many men have worked hard in arranging for conferences and general meetings.

Of course it is discouraging to these men not to have a good number interested enough to attend.

The program at Waterville this year was very good indeed, and the evening meetings were fairly well attended, but many of the conferences during the day were not attended as well as they deserved.

Of course the weather at this time of year is uncertain and many do not like to drive at night, especially in bad weather.

It has been suggested that perhaps we should discontinue the State Fall Clinical session and have instead several regional meetings, at the hospital centers—possibly one day affairs in which several counties grouped together would take part.

This plan would have the advantage of cutting down the distances to be travelled and might work better.

It would be a good idea to consider this matter and for it to be discussed at the County meetings so that the Scientific Committee and the Council may have some expression of opinion to help them in deciding.

George L. Pratt, M. D.,
President Maine Medical Association.

Editorials

Is It Fair Play?

When one compares the limitation of medical and hospital service, when many now in active practice were commencing their professional careers, with the exacting and rapidly changing demands of today the questions arise; is there a commensurate ability on our part to appreciate their significance and ultimate outcome; are we adapting ourselves, as a profession to conditions of fact and is organized medicine through its national and component state associations preparing properly for the changes that are sure to come in a manner that will insure to the public and the rank and file of the profession that which is best for the protection and best interests of all?

The vast and far-reaching propaganda issued to the public, by those with selfish interests and not always outside of the profession, has created a feeling of uncertainty and perhaps resentment and added to that, within our own ranks, autonomous societies, self-appointed committees and officially designated boards have assumed or been granted powers and authority that make careful and thinking men seriously consider the ultimate results. The American Medical Association prides itself on its democratic methods of procedure and set-up, stands before the country as the official body of some 115,000 physicians, the majority being general practitioners. Many of these in the middle-aged and older groups have by application and aptitude developed special technical skills in the many specialties of medicine which have been awarded merited recognition by their immediate colleagues and the public they serve. What then is the standing of these practitioners now to be since the various specialty and certifying boards have been implemented with an authority and power already becoming more and more manifest? One of the main objections to the Wagner bill, as emphatically expressed by organized medicine, was the fact that the profession would be under bureaucratic control and dictation, yet the American Medical Association evidently deems it proper and fair to endow the specialty boards with authorities and power seemingly far from democratic in ideals or methods of procedure and also it might be questioned; with the approval of the membership as a whole.

When the American College of Surgeons formulated the requirements for Fellowship, it was recognized with wisdom and equity, that practitioners in communities of definitely designated populations could and should not be held to strict limitation of practice in their special fields. A certain minimum was established; through the central and state credentials committees candidates for fellowship submitted their qualifications and by them were judged, with the sole object to be determined, whether the applicant was or was not a competent, ethical and capable practitioner in his elected field of endeavor. The thought has recently been expressed that the College should correct its tendency to become too inclusive so that it will not foster the performance of surgery by those inadequately qualified. Evidently, the speaker felt that the College was shaking the bushes and that a restraining hand was needed. However, the American College of Surgeons is and has been for many years, a recognized institution of fact, with creditable and far-reaching accomplishments. BUT with the creation by the American Medical Association of the specialty and certifying boards one may pertinently ask; what Now the worth of its Fellowship degree; are the "specialists in medicine" to be solely determined by boards created under the Council of Medical Education and Hospitals of the American Medical Association sanctioned by the House of Delegates; does certification depend on the fact that a physician limits his work exclusively to a certain line or should it be based on the fact that one is capable of doing a certain job unusually well and had been doing it long, long before the specialty boards came into existence.

As one commentator aptly puts it; with the publication of the directory of medical spe-

cialists the specialty boards "will deliver another blow at the unrecognized specialists since only specialists *approved* by the boards will be included in the volume." From the same source one learns that a committee is organizing what it hopes will be a rival of the American Medical Association since one of its important purposes will be to duplicate in *group medicine* the work done by the A. M. A. The opponents of organized medicine today are many. That they will lack the acumen to profit by any disruption that may occur if absolute power as to rating and standing of the practitioners of this country is vested in boards, the membership of which is composed of those belonging to societies of an admitted exclusive type, and whose dictates should have no part in a national organization of practitioners is hardly to be expected. It might be pertinent to point out that the practice of medicine still remains a privilege to be granted an applicant by a given state, provided one meets with stipulated requirements, which requirements are not becoming less easy.

The Annual Conference of State Secretaries and Editors

An annual affair, the 1939 conference was held at the headquarters of the A. M. A., Nov. 17th and 18th. One fact can be stated with emphasis. The American Medical Association has a definite and stated program for the betterment of medical care and its distribution. That it will confer and cooperate to the fullest possible extent with any designated Federal or State agency is an assured fact. This coöperation will be active and constructive and it seemed to be the universal opinion of those present that not only can we help in the development of the changes that are sure to come, some of them admittedly needed, but that our services will be welcome. This is certainly a most agreeable fact. Without question the Wagner Health Bill, if presented under that title, will differ materially from the one presented at the last Congress by Senator Wagner which it is admitted could and would not work. Space does not allow anything like a full presentation of the various topics that were discussed, the Journal, however, prints in the present issue the platform that is proposed by and will be heartily supported by the American Medical Association and which has the hearty approval of the board of trustees.

When the draft of the new health bill is completed, it undoubtedly will be submitted to the American Medical Association for suggestions and amendments to insure its not only being acceptable to the profession but that it will afford the greatest possible benefit and protection to the people of this country. Certain things can be done by organized medicine as a unit and by the American Medical Association as its recognized representative, but it is extremely important to bear in mind, it cannot be stated too strongly or too frequently, that when the time comes for the profession to assert itself every individual of the component State associations has an important duty to perform to personally write to their representatives in the House and Senate if and when there are features in the bill deserving criticism. If the submitted bill contains proposals that are liable to disrupt the practice of medicine on the type that it exists in this country, if it offers or contains an opportunity for bureaucratic control or anything else hostile to the ideals of a profession practicing under a democratic form of government it becomes each and every one of us to so inform our representatives in Washington.

Your secretary-treasurer and chairman of the editorial board of the Journal feel that the ultimate results of this meeting can be only for the best. The papers and discussions, some of which will appear in the Journal of the American Medical Association, should be read carefully since they bring to the profession the experiences and opinions of men extremely well qualified to speak. Certain phases of the meeting, devoted more to State than National legislation, carried definite and concrete suggestions how each State Association as a unit and we as individuals can and should combat legislation hostile and unfair. A résumé of this important subject will be presented at the annual meeting of the Association in Rangeley next June.

County News and Notes

Cumberland

A meeting of the Cumberland County Medical Association was held at Portland on Thursday, November 9, 1939.

Clinical Session at the Maine General Hospital at 4.45 P. M., at which the following cases were presented:

Pre-operative Radiation in Selected Cases of Cancer of the Breast—Jack Spencer, M. D.

Longevity in Coronary Thrombosis — E. H. Drake, M. D.

500 Unselected Hospital Patients, Skin-tested for Undulant Fever—E. R. Blaisdell, M. D.

Polypoid Growth of Stomach—I. M. Webber, M. D., and E. R. Blaisdell, M. D.

Chronic Suppurative Mastoiditis with Brain Abscess—C. H. Gordon, M. D., and H. E. MacDonald, M. D.

Dinner at the Eastland Hotel at 6.45 P. M., followed by a business meeting. Gordon N. Johnson, M. D., of Portland, and Philip Gregory, M. D., of Boothbay Harbor, were elected to membership.

The speaker of the evening was Leland Powers, Attorney, of Boston, whose subject was *The Doctor in Court.*

HAROLD V. BICKMORE,
Secretary.

Portland Medical Club

The regular monthly meeting was held at the Columbia Hotel, November 7, 1939, at 8.15 P. M. The President, Dr. E. E. O'Donnell, presided. There were 47 members and one guest present.

Dr. Harry E. Christensen and Dr. James M. Parker were admitted to membership.

Resolutions on the death of Dr. Carl C. Corson were adopted by the Club.

The following committees were appointed:

Annual Banquet: Dr. T. A. Foster, Dr. R. S. Hawkes, Dr. A. A. S. Whittier.

Nominating Committee: Dr. E. R. Blaisdell, Dr. P. H. McCrum, Dr. Mortimer Warren.

A very instructive scientific program was presented by Dr. Langdon T. Thaxter and Dr. Jack Spencer on *The Use of X-ray in the Study of the Acute Abdomen.* The paper was discussed by Dr. Carl Robinson, Dr. Frank Lamb, Dr. I. M. Webber and Dr. E. E. O'Donnell.

ALICE WHITTIER, *Secretary.*

Kennebec

A meeting of the Kennebec County Medical Association was held at the Gardiner General Hospital on Thursday, November 16, 1939.

Clinical Session at 5 P. M., which was presided over by Leon D. Herring, M. D., President.

1. A Case of Appendiceal Abscess—George B. Alexander, M. D.
2. T. B. Spine Case with Neurological Complications—Harry Almond, M. D.
3. A Case of Fatal Undulant Fever—C. R. McLaughlin, M. D.
4. A Case of Cerebral Fungus—Frank B. Bull, M. D.
5. A Case of Inversion of the Uterus—I. E. McLaughlin, M. D.
6. Recovery from Septicaemia and Carbuncle, aged 91—C. G. Farrell, M. D.

Dinner at 6.30 P. M., followed by a business meeting. Minutes of the last meeting were read and approved. Clarence John Kenney, M. D., of Togus, Maine, was elected to membership.

The address of the evening was given by Robert Linton, M. D., Assistant Professor of Surgery, Massachusetts General Hospital, whose subject was *Peripheral Vascular Diseases.* Many interesting and instructive points were brought out in this paper and we were fortunate in having Dr. Linton with us.

There were 33 members and guests present.

Respectfully submitted,

FREDERICK R. CARTER, M. D.,
Secretary.

Penobscot

The annual meeting of the Penobcot County Medical Association was held on Tuesday, November 21st. The usual routine business was carried out. Three new members were elected, Herbert Thorndike Clough, Jr., of Bangor, Richard T. Munce of Bangor, and Walter L. H. Hall, of Old Town.

The following officers were elected for 1940:

President: Allan Woodcock, Bangor.

Vice-President: E. P. Goodrich, Winterport.

Secretary-Treasurer: Forrest B. Ames, Bangor.

Board of Censors: W. M. Emerson, Bangor; A. C. Adams, Orono; L. H. Cutler, Bangor.

Delegates to Maine Medical Association annual

Your Membership Expires December 31st

session: H. C. Scribner, Bangor; L. J. Wright, Bangor; H. C. Knowlton, Bangor; F. B. Ames, Bangor.

Alternates: C. H. Burgess, Bangor; H. D. McKay, Old Town; L. H. Smith, Winterport; A. C. Strout, Dexter.

Dr. P. L. B. Ebbett, Councillor for the District, was present, and Dr. George Pratt of Farmington, President of the Maine Medical Association, also, as guests.

The speaker of the evening was Joseph T. Smith, M. D., of the Pratt Diagnostic Hospital in Boston, who spoke on the subject, *Eclampsia.*

There were sixty-three present.

FORREST B. AMES, M. D.,
Secretary.

Somerset

Somerset County held the regular Fall meeting in Skowhegan for the first time in many years. It has been our custom to hold this session in the northern section of the county as a game dinner has usually been furnished by members living where game is more plentiful.

This year it was decided to hold a clinical session at the Redington Memorial Hospital in Skowhegan, November 9, 1939.

We were fortunate in securing for this occasion Dr. William Damshek, Professor of Medicine at Tufts College, who conducted the clinic.

The following cases were presented and discussed by Doctor Damshek:

1. Aplastic Anaemia, which was discovered following a traumatic injury to head and neck—Dr. H. E. Marston of No. Anson and Dr. R. P. Laney of Skowhegan. Dr. G. E. Young of Skowhegan discussed the case from the traumatic point of view.
2. Splenomegaly following cholecystectomy complicated with a cystic thyroid—Dr. G. E. Sullivan of Bingham.
3. A case of Blood Dyscrasia with Splenomegaly—Dr. R. P. Laney of Skowhegan.
4. Polycythemia—Dr. F. P. Ball of Bingham.
5. Chronic Asthma in a female of 26 dating back to five months of age—Dr. M. E. Lord of Skowhegan.

A large attendance of members and guests added to the interest of the occasion.

A game dinner furnished by two of our members was served in the Masonic dining room at 6.30 in the afternoon, following which Dr. Damshek gave an interesting talk on the subject of *The Anaemias.*

MAURICE E. LORD,
Secretary.

Washington

The Washington County Medical Society met on October 11 at Machias. Dinner was served at the Universalist Church vestry at 6.30 P. M., followed by a meeting at 7.30 in the church auditorium. Twenty-two members and guests were present.

In the absence of President John T. Metcalf, M. D., of Lubec, Oscar F. Larson, M. D., presided.

The principal speaker of the evening was Garry Hough, M. D., of Springfield, Massachusetts, who is assistant to R. N. Hatt, M. D., of the Shriners Hospital. Doctor Hough spoke fluently and at length on *Recognition and Treatment of Common Orthopedic Conditions Present at Birth.*

Carlton Rand, M. D., of Lewiston, Orthopedic Surgeon for Maine's Crippled Children's clinics, spoke interestingly on *Back and Foot Conditions, their Recognition and Treatment by the General Practitioner.*

Herbert R. Kobes, M. D., Director of services for crippled children made a few timely remarks relative to his work for crippled children.

We were pleased to have with us George L. Pratt, M. D., of Farmington, President of the Maine Medical Association, who spoke on legal matters coming up at the next legislature that he deemed of interest to the general practitioner.

Respectfully submitted,

OSCAR F. LARSON, M. D.,
Secretary.

New Members

Cumberland

Gordon N. Johnson, M. D., Portland, Maine.
Philip Gregory, M. D., Boothbay Harbor, Maine.

Kennebec

Clarence J. Kenney, M. D., Togus, Maine.

Penobscot

Herbert T. Clough, Jr., M. D., Bangor, Maine.
Richard T. Munce, M. D., Bangor, Maine.
Walter L. H. Hall, M. D., Old Town, Maine.

Removal Notices

George W. R. Bowie, M. D.
From Rangeley, Maine
To New Gloucester, Maine

R. E. Williams, M. D.
From New Gloucester, Maine
To Freeport, Maine

E. D. Humphreys, M. D.
From Jackman Station, Maine
To 91 Main Street, Pittsfield, Maine

Notices

Venereal Disease Clinics

For the information of physicians wishing to refer cases of venereal disease for treatment, the State Bureau of Health announces that such facilities are available in the following locations:

Augusta, Bangor, Bath, Belfast, Biddeford, Bingham, Calais, Danforth, Eastport, Ellsworth, Grand Isle, Guilford, Houlton, Island Falls, Lewiston, Millinocket, Old Town, Portland, Presque Isle, Rockland, Rumford, Sanford, Waterville, Wilton, Winthrop.

Any physician wishing to refer a case may obtain the name of the clinic physician, in the town where the patient is to receive treatment, on request to the Director, State Bureau of Health, Augusta, Maine.

Tumor Clinics

Bangor: *Eastern Maine General Hospital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Magnus F. Ridlon, M. D.*

Lewiston: *Central Maine General Hospital*
Tuesday, 10.00 A. M.-12.00 M.
Director, *E. V. Call, M. D.*
St. Mary's General Hospital
Wednesday, 4.00 P. M.
Director, *R. A. Beliveau, M. D.*

Portland: *Maine General Hopital*
Thursday, 11.00 A. M.-12.00 M.
Director, *Mortimer Warren, M. D.*

Waterville: *Sisters Hospital*
1st & 3rd Thursdays, 10.00 A. M.
Director, *B. O. Goodrich, M. D.*
Thayer Hospital
2nd & 4th Thursdays, 10.00 A. M.
Director, *E. H. Risley, M. D.*

Bureau of Health
Services for Crippled Children
Clinic Schedule

Bangor: *Eastern Maine General Hospital*
Thursday, 1.00-3.00 P. M
December 14, January 11

Waterville: *Thayer Hopital*
Thursday, 1.30-3.00 P. M.
January 25

Rockland: *Knox County Hospital*
Thursday, 1.30-3.00 P. M.
December 21

Portland: *Children's Hospital*
Monday, 9.00-11.00 A. M.
December 11, January 8

Lewiston: *Central Maine General Hospital*
Saturday, 9.00-11.00 A. M.
December 30, January 27

Rumford: *Rumford Community Hospital*
Wednesday, 1.30-3.00 P. M.
January 31

Machias: *Normal School*
Wednesday, 1.00-3.00 P. M.
January 17

N. B.: This clinic schedule is subject to change. If changes are necessary adequate notice will be given.

American Board of Ophthalmology

Written Examination, March 2, 1940, in various cities throughout the country.

This will be the only written examination in 1940.

All applications for this examination must be received before January 1, 1940. All applicants must pass satisfactory written examination before being admitted to oral examination.

Oral Examination: New York City, June 8th and 10th. Fall examination to be announced later.

Case Reports: Candidates planning to take June examination must file case reports before March 1st.

For application blanks write *At Once* to Dr. John Green, 6830 Waterman Avenue, St. Louis, Missouri.

For Sale

Retiring from practice, I wish to dispose of my office fixtures and surgical appliances, including a fairly large supply of instruments (including eye, ear, nose and throat, gynæcological, male urethral, bone instruments, operating chair, roll-top desk, chairs, instrument trays, sterilizer and books). A fine chance for one practicing at a distance from surgical centers.

George F. Bates, M. D.
486 Woodford Street, Portland, Maine
Dial 2-5683

Necrologies

John Witham Nichols, M. D., 1859-1939

Doctor John Witham Nichols, oldest practicing physician, not only in his home town of Farmington, but in all Franklin County, died at the Franklin County Memorial Hospital, Farmington, on October 3rd, of coronary occlusion, having been seriously ill less than twenty-four hours, and having made his daily round of calls upon his patients the preceding day.

Doctor Nichols was born in Searsport, Maine, on August 4, 1859, and when he was nine years of age his parents moved to Farmington, where he received his early education in the common schools, fitting for college at the Wendell Institute.

In 1881 he was graduated from Bowdoin College, and from the Medical School of Maine in 1887, and with the exception of two years in the early 1890's, when he was physician of the Keeley Institute of Vermont, located in Montpelier, he has followed his profession in this town and county up to the day of his death.

He was a member of the Franklin County Medical Society, the Maine Medical Association and the American Medical Association, and a member of the Staff of the Franklin County Memorial Hospital from its organization, being its first President; and also a member of the Masonic Bodies and the Knights of Pythias.

In 1937 he received the Honorary Fifty-Year Gold Medal from the Maine Medical Association.

On June 7, 1892, he married Bertha E. Johnson of Industry, who died in 1910.

On October 30, 1912, he married Marian H. Pomeroy of New Sharon, who survives, as does the daughter by his first marriage, Miss Alice Nichols, and a niece, Mrs. Mabel Furst, both of New York City.

Franklin County knows that it has lost a citizen of the highest character, and a loyal friend.

The doctors knew him as one of the best physicians in the State, whose keenness in diagnosis and sound judgment and friendly personality caused him to be called in consultation more often, probably, than any physician in this section of Maine.

He died "in harness," as he wished, and his memory will long be cherished by very many who are grateful for the privilege of having known him during his life.

CHARLES W. BELL.

Carl Cutting Corson, M. D., 1905-1939

Doctor Carl Cutting Corson died suddenly in Portland on October 3, 1939, in his thirty-fourth year.

He was born in Everett, Massachusetts, on December 5, 1905. Shortly afterward his family moved to Bridgton, Maine, and there made their home. He attended the local schools in Bridgton and then for a year the Cambridge Latin School. In 1928 he graduated from Harvard College with the degree of A. B., and in 1932 from Harvard Medical School. Further training included a brief term at the Mattapan Sanatorium, a surgical internship at the Boston City Hospital, and an internship in orthopedic surgery at the Massachusetts General and Boston Children's Hospitals. These were followed by a year as resident orthopedic surgeon at the Massachusetts General Hospital.

In January, 1937, Doctor Corson came to Portland where he limited his practice to orthopedic surgery. Subsequently he made his home in Yarmouth. He was on the Staff of the Maine General Hospital, the Children's Hospital, and the Maine Eye and Ear Infirmary in Portland, and was consultant in orthopedics at the Bath Memorial Hospital. He was a member of the Boston Orthopedic Club.

Sympathy is extended to his wife, Mrs. Esther Alden Corson, his two sons, John Alden and David Jackson, his father Walter Corson of Bridgton, and his brother Benjamin of Chicago, Illinois.

During the brief space of less than three years few men have so completely earned the admiration of their colleagues for diagnostic and surgical skill, the regard which he won as a man.

George Arthur Neal, M. D., 1872-1939

George Arthur Neal, M. D., died suddenly on the morning of September 17, 1939, from an attack of coronary thrombosis.

He had been in failing health for about one and one-half years, when he suffered his first attack of coronary occlusion.

His father, Doctor Elias Neal, died from the same disease about forty years ago, while in attendance on an obstetric case, on Cranberry Island, Maine.

Doctor Neal was born in Pembroke, Maine, on February 16, 1872.

He fitted for college at Westbrook Academy, and was graduated from the Baltimore Medical College in 1905.

After graduation, he at once began the practice of Medicine at Southwest Harbor, Maine, and remained there the rest of his life.

Doctor Neal always took a great interest in town affairs, having served on the School Board for six years, was Superintendent of Schools for two years, and took an active part in the work of the Red Cross Society, and Village Improvement Association, and the Chamber of Commerce.

He was one of the most loyal members of the Maine Medical Association, seldom missed an Annual Meeting, and served on important Committees.

For twenty-one years he was Secretary of the Hancock County Medical Society, and was the most influential and devoted member of that organization.

After resigning as Secretary he served as President of the County Society until his death. Few doctors in the state can equal this record.

Doctor Neal was a member of the Staff of the Mt. Desert Island Hospital for many years, and for the past two years served as President of the Staff.

The Hospital benefited, in a large measure, by the many patients he referred to the institution, from his practice.

It was my privilege to be closely associated with him for more than thirty years, and I never knew one who could surpass, and few equal, his cheerfulness and optimism, his honesty of purpose, and kindliness toward all.

Although handicapped from childhood, by lameness, no night was too dark, no storm too severe, and no traveling too rough, that he would not cheerfully respond to calls, not only in his own community, but to surrounding towns and to adjacent islands.

His colleagues and his patients loved and respected him, and he deserves the highest award, not only for his thirty-four years of faithful and efficient service, but for his professional skill as well.

I consider Doctor Neal one of the finest examples of the general country practitioner.

There is left to mourn him, his widow, Mrs. Bertha Neal, and his brother, Mr. Wilder Neal.

Ralph W. Wakefield.

Book Reviews

"The Mechanisms of Thought, Imagery, and Hallucination"

By Joshua Rosett, Professor of Neurology in Columbia University, Scientific Director Blain Research Foundations, Inc., New York. Published by Columbia University Press, New York, 1939. Price, $3.00.

This is an original work. The author spent a great deal of serious hard work in the attempt to solve the problem which has remained unsolved through the ages preceding our own. He hoped to supply for educators and the medical profession basic concepts for the mechanism of thought, imagery, and hallucination. Under controlled conditions he studied both animals and human beings and discovered, among other things, that "the changes which take place in the living body as a result of its collision with the surrounding forces constitute the physical basis of the emotions; the external manifestations of these changes constitute the expression of the emotions; and these are indexed by certain changes in the nervous system known as the feeling of the emotion" also "an emotion includes the following four factors: (1) the cognition or recognition, or the memory of a certain situation, the act resulting in certain internal disturbances implied by the subjective experience of sensation, which may be of different degrees of clarity; (2) the feeling which accompanies the internal disturbances, which is graded in terms of intensity; (3) the internal disturbance itself; that is, the activity of the visceral and vascular organs, which is the emotion proper; (4) the expression of these changes by muscular movement or in other ways.

"The inclusion of these four factors in the concept of the emotional state reconciles the James-Lange theory with the modern viewpoint of the emotions."

Having established a general conception that the conscious that exists in the medium of the emotions, based upon anatomic and physiologic structure and function, he undertook to study human thought, imagery, and hallucination on persons who suffered from injuries, tumors, convulsions and intoxication and concluded that "the function of thought may be defined as a subjective reproduction of objective experiences, in which orientation in the past is co-existent with and guided by a large amount of orientation in the present; and which, notwithstanding the vagueness of the sensations re-experienced, is accurate with respect to their relations as they are integrated into memories and situations. Increasingly smaller amounts of orientations in the present, making for a greater degree of vividness of the subjective reproduction of objective experiences and correspondingly increased degrees of inaccuracy of the relations of their elements, constitute imagery and hallucination."

To all appearances many of the author's conclusions are drawn by analogic comparisons of human emotions with emotions of animals and with operations being performed by inanimate objects or by highly perfected mechanical devices, such as are found in motion in complicated machinery. Even in a work of this type the comparison of the operation, motion and commercially useful or useless output of the finished product of a man-made machine with the physiologic function, emotion and the commercially or sociologically useful or useless intellectual output of man himself represents a chain of errors in the technique of true to fact thinking which demands careful clarification.

It is often permissible in the medical sciences to try to elucidate a theory by analogy but in the opinion of this humble reviewer human thought in any of its forms, being admittedly complex in its nature, cannot readily be compared with anything that occurs in the animal world and cannot at all be compared with a complicated piece of machinery which is the end-product of the most highly developed branch of human thought, the calculating intellect. When we try to investigate human thought in health by studying human beings whose thoughts, imageries, hallucinations, emotions are designated as abnormal as compared with the normal, or when we subject normal human beings to any form of experimentation, as physician we must know and always remember that symptoms of derangement of function due to disease processes and symptoms of response due to experimentation may point the way to the study of normal function but both tend to and often do lead us astray in our reasoning and in our conclusive judgment. Symptoms are answers with which the organism under investigation responds to the modification forced upon it by disease or by command of the experimenter and many express attempts at readjustment or protests against disturbance of an established adjustment. Often no symptomatic response can be released by either disease process or experimental manipulation. The symptom of the response to a stimulation is determined not only by the so-called mental attitude of experimenter and experimentee, by the operation of the stimulating object and the stimulated subject, but also by the evaluation of the result which depends upon the experimenter's motive and his biased or prejudicial attitude which in turn determines his final judgment. Physical, physiological, chemical, physiochemical, electro-chemical, psychological, etc., experimentation carried on in the non-human, in the altered living or the dead human, or outside the human body, can never bring us nearer an understanding of the functioning of any of the processes going on within, and only within, the living human body. Nor can reliable conclusions be drawn from experimentation carried on upon the sleeping, or the narcotized or the comatose or the unconscious body in regard to prediction of the behavior of the wakeful normally functioning body, which may or may not be alert to the requirements of his position in a more or less hostile environment not of his own making, against which he must assert himself.

The emergencies of every day life which we are expected to meet successfully approach us like accidents, unpredictably, and the appropriateness or the sanity of our response can be appraised only after the act, in retrospect as it were, when thinking becomes possible and necessary for the formation of an evaluative judgment concerning the appropriateness of the behavior with regard to the solution of the emergency situation problem. One needs only to try to predict one's probable behavior when suddenly confronted by mechanical or metaphysical (ideologic, technologic, etc.) expediencies to which we must adjust ourselves many times during every day of our life in order to comprehend the full weight of the responsibility placed on the nervous system.

Valuable as the present study is, it could be made much more so if in future editions more of the so-called psychogenic factors were included as basic causes for initiating human thought, imagery, hallucination. There should also be a greater adherence to established terminology. The work of clarification of concepts must go on and all branches of the medical sciences must become engaged in the undertaking. The present author must be congratulated for his success thus far. One is inclined to share his hopes of finding more answers to many of today's burning questions in matters of human thought, imagery and hallucination.

"Priests of Lucina—The Story of Obstetrics"

By Palmer Findley, M. D., F. A. C. S. Published by Little, Brown and Company, Boston, 1939. Price, $5.00.

So-called priests and priestesses of Lucina (Eileithyia of Homer, daughter of Hera, protecting goddess of the childbearing woman in labor) have travelled a long way. They have served parturient womankind for thousands of years before and since the written history of the creation of man was begun. Then as now they met with much favorable and unfavorable criticism both from members of the society in which they lived and practiced their art as well as from members of their profession. In spite of this opposition, however, they persisted and still persist in giving to the woman in labor whatever help was and is possible to give. This help always did and still does depend largely upon the amount of knowledge and skill which each individual practitioner could and can accumulate and perfect by successive experiences of various kinds.

It is well that the historic epochal highlights of obstetrical services have been rediscovered and brought before the present-day reader in such excellent form and style as was done by the author of this book. Midwifery and obstetrics have always been a service which was performed by practitioners of more or less firm beliefs and convictions, mythical, mystical, religious, technical, scientific, etc., and the practices of one were often quite contrary to the practices of the majority so that there was always ample opportunity for disputations. However, in spite of all assertions of individualisms of various kinds the human race survived, multiplied, and is better today in many ways than it was during any one millennium historically known to us. We have learned more and acquired more skill, discovered new techniques and developed safer methods and rules of procedure. Dr. Findley's contribution to the popularization of the story of obstetrics among the medical and allied professions is highly illuminating, instructive and inspiring. It is the story of progress made by man on his road from the primitive to a more highly cultivated civilization, of his numerous maneuvers to aid nature by the trial and error method to do better and almost free from accidents and suffering what should be done well through normal functioning of the female organism. Man hoped to attain whatever improvement could be hoped for by the invention and application of mechanical contrivances, verbal exhortations, exemplifications, expostulations, chemical compositions, etc.

Wise men forever remind man born of woman that the acquisition of the knowledge of that paradisial fatal truth that man once born is bound to die made him free to exercise all his faculties in an effort to discover means and methods by which he may ultimately lessen or entirely remove pain and suffering from the processes of human birth, of life and perhaps of death. Thus the noble work of the healer-priests goes on, now and then in epochal spurts, usually in slowly advancing stepwise improvement of the daily routine in the services rendered to those who need help and may or may not ask for it.

The practice of obstetrics has been largely in the hands of midwives from the time preceding Hippocrates up to the time of the birth of our own mother's sons and daughters. Only during the past hundred years did changes occur which tend to lead us toward male domination of the field of midwifery by the physician specially trained for obstetrical service.

Doctors, nurses, midwives and other members of the medical and allied professions will find "Priests of Lucina" most interesting and highly instructive literature. The cruelties of human kindness are many and varied indeed.

"Medico-legal Phases of Occupational Diseases—An Outline of Theory and Practice"

By C. O. Sappington, A. B., M. D., Dr. P. H., Consultant, Occupational Diseases and Industrial Hygiene. Formerly Director of Industrial Health, National Safety Council; formerly special lecturer on Industrial Hygiene and Occupational Diseases, University of California, Stanford Medical School, University of Michigan, University of Illinois Medical School, and Rush Medical School. Published by Industrial Health Book Company, Chicago, 1939.

Industrial medicine has become a very vital branch of the medical sciences and promises to become even more so as the development of our technocratic civilization progresses and our mechanical and political expediencies intensify their hold on mankind. The author of this book tries to ease the burden of the occupational disease treating physician by telling him of the many angles which the care of a person fallen ill with any form of disease while actively engaged in earning a living by working for it may present.

There are five major sections to this work. In Part One the various reasons for the occurrence of occupational disease conditions are given, and the English and the American classifications of most of the agents known to harm the human organism in some way or other are briefly described. Part Two deals with the various phases of the problem of insurance against sickness and loss of wages. In Part Three are disclosed the complicated medical problems which may evolve during the time the treating physician dutifully tries to establish etiology and diagnosis, prescribe or actively give appropriate treatment, estimate length of disability and arrange for ways and means to prevent recurrences, etc. The Fourth Part deals with legal and medico-legal questions concerning compensation legislation, adjustments of financial remuneration and so on. The larger part of the remainder of the book is devoted to abstracts of state laws and of legal decisions. The author does not promise that he will remove the difficulties you must meet while engaged in industrial medicine and surgery; he simply tries to prepare you to meet them more successfully.

"Microbiology and Pathology"

By Charles F. Carter, B. S., M. D., Director, Carter's Clinical Laboratory, Dallas, Texas; Consulting Pathologist, St. Louis South Western Railway Hospital, Texarkana, Arkansas; Consulting Pathologist, Mother Francis Hospital, Tyler, Texas; Formerly Director of Laboratories, Parkland Hospital, Dallas, Texas; and Lecturer in Bacteriology and Pathology, Parkland Hospital School of Nursing. 753 pages with 165 Text Illustrations and 25 color plates. Second Edition. Published by The C. V. Mosby Company, St. Louis, 1939. Price, $3.25.

Encouraged by the kind reception which the first edition received, the author now presents this new revised and enlarged work. The general style and set-up has been maintained, some new illustrations have been added, and the laboratory exercises have been extended. The publication of this book is based on the author's desire to supply knowledge of microbiology and pathology for the nursing profession that may enable the student as well as the graduate nurse, to do her share in the recognition and prevention of disease producing organisms and processes. He believes that since the nurse, like the doctor, spends a great part of her professional life among people suffering from infectious diseases, she owes it to herself and her patients to familiarize herself with these organisms and processes so that she may recognize their physical shapes and functional characteristics and learn to fortify herself, her patients and the community against their massive actions with all the means that are at her command at the present stage of our knowledge.

"Do You Want to Be a Doctor?"

By Morris Fishbein, M. D., Editor, *Journal of American Medical Association.* Published by Frederick A. Stokes Company, New York. 1939. Price, $1.50.

This is the second volume of the Stokes Vocational Guide Series. The first volume is entitled: "Do You Want to Become a Banker," and was written by Wilbur F. Crook, President of the Chemical Bank and Trust Company of New York. Future vocational guide books in this series are promised by the Frederick A. Stokes Company on such subjects as Journalism, Law, Engineering, Accounting, etc.

The present volume, written by the able hand of Dr. Morris Fishbein, is intended to supply all the necessary information any young man of college age will need in the future in order to survey his chances of becoming a doctor of medicine in the United States of America or in Canada. In synoptic form, the essential requirements for entering a medical school and for graduating from one with a reasonable guarantee for success in the practice of medicine, surgery or any one of the twenty-five specialties listed in this book are presented. The legal requirements which must be met in every state are shortly and clearly outlined.

The information given here is strictly up-to-date and every young man who is thinking of entering upon a medical career should be thoroughly familiar with it in order to fortify himself against serious and expensive disappointment. Doctors will find almost all the answers to the questions asked by ambitious young men in their community.

SILVER PICRATE *Wyeth's*

has shown a

CONVINCING RECORD OF EFFECTIVENESS *in* ACUTE ANTERIOR URETHRITIS

due to Neisseria gonorrheae

The record is based on rigid clinical and laboratory signs before and after treatment.*

1. Fresh smear
2. Fermentation of dextrose
3. Acid formation in maltose
4. Agglutination test
5. Alkali solubility test

Silver Picrate is a crystalline compound of silver in definite chemical combination with picric acid. Dosage form for use in Anterior Urethritis: Wyeth's Silver Picrate Crystals used in an aqueous solution of 0.5 percent.

Supplied at all pharmacies in vials of 2 grams

Complete literature on Silver Picrate as used in genito-urinary and gynecological practice will be mailed on request.

*"Treatment of Acute Anterior Urethritis with Silver Picrate," Knight and Shelanski, AMERICAN JOURNAL OF SYPHILIS, GONORRHEA AND VENEREAL DISEASES, Vol. 23, No. 2, pages 201-206, March, 1939.

JOHN WYETH AND BROTHER, INC. • PHILADELPHIA, PA.

Officers of the Maine Medical Association

1939-1940

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